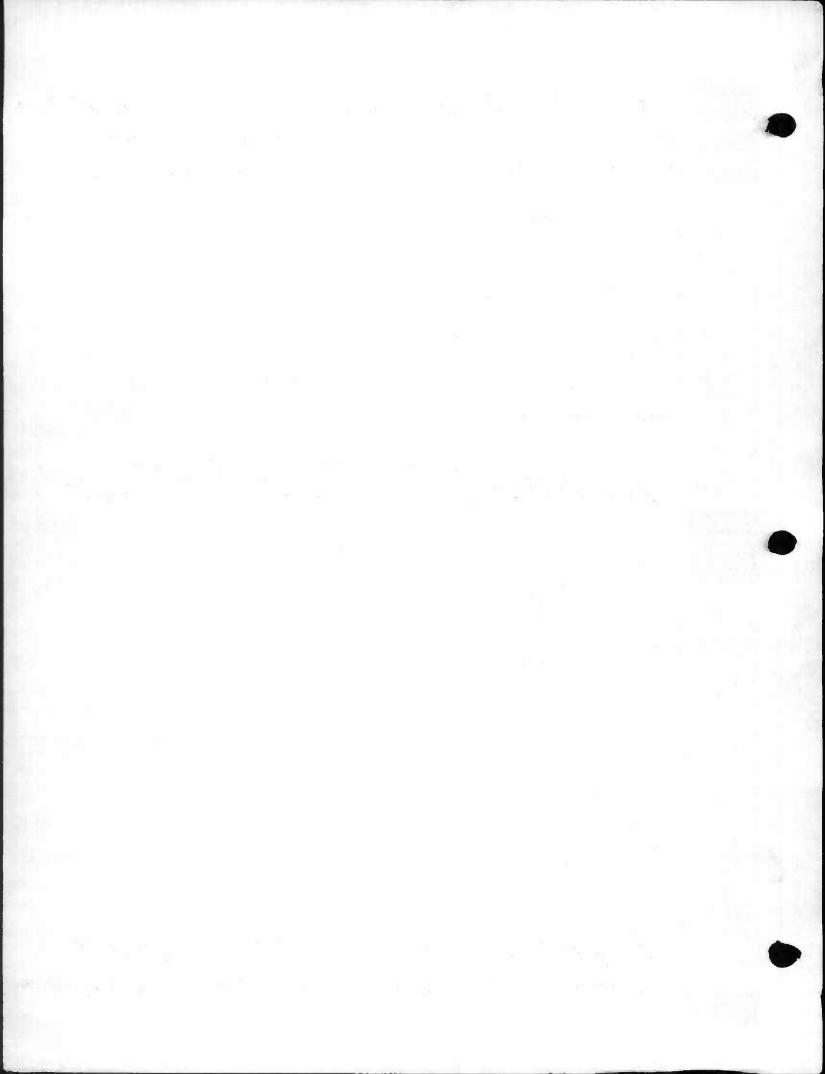
State of Maryland / Department of Health and Mental Hygiene

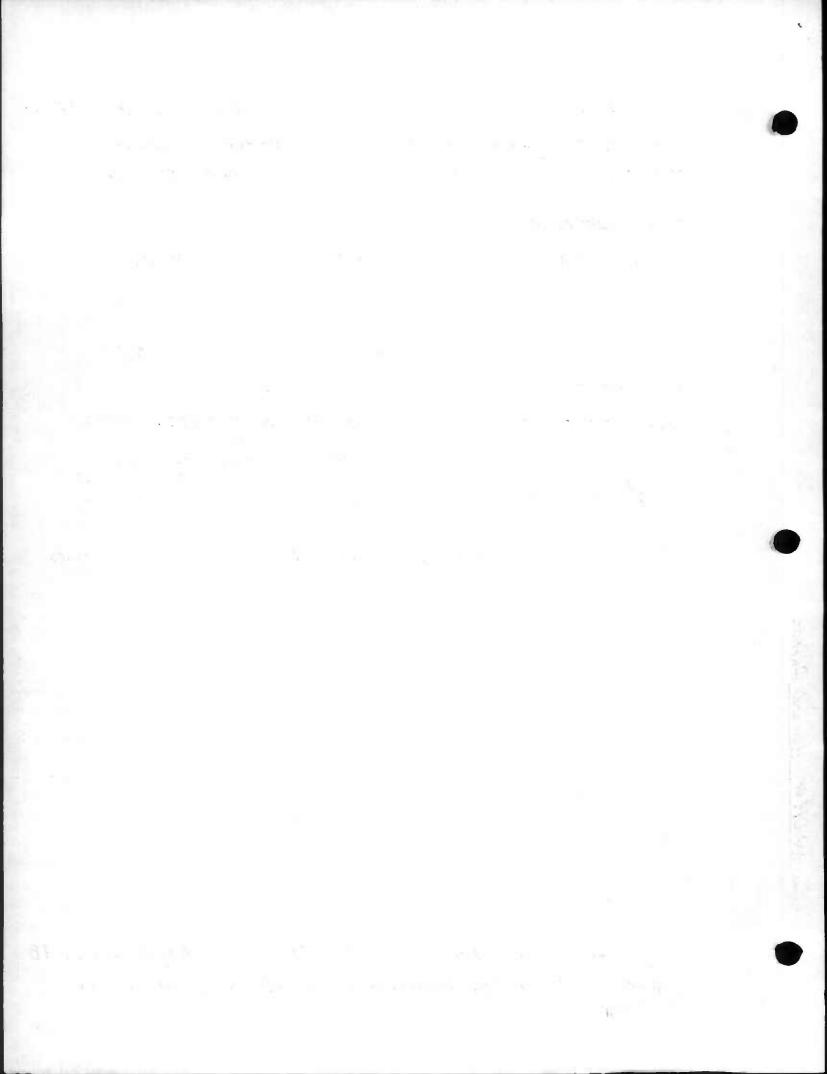
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Funeral Director			M 201	Aga (III yis.		Months Day				9. Birthpia Country ITAL	ca (Stata or Foraign y) Y
ž ==		10a. Stata 10b. County		10c. City	y, Town or Loca	tion			-	100	d. Inside City Limits
28a-f show notified at	Ö	MD HOW	ARD				COLUMBIA	A			1 ☐ Yas 2XX
or 28a	9	10e. Sfreet and Number				10f. Zip Coda			10g. Citizan of	What Country	y?
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dical Exa	8	15. Decedent's Ed	ucation	0.	18a. Decedar	nt's Usuai Occ	upation		16b. Kind of B		
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vent,	ge C	17. Fathar's Nama (First, Middla, Last)						ama (First, Middla,	The state of the s		
op .	0	PASQUALE MAGNA	RELLA				ALES	SANDRINA	(SPADA	4)	
important: If them 27 is marked other any injury or other traumatic event, once.		19a. Informant's Name/Ralationship (7 CHRISTINE KLEINKE		ER)				Rural Routa Numbe			Code)
e e		20a. Mathod of Disposition 11√2 Burial 2 ☐ Cramation 3 ☐	Damaual from Sta		laca of Disposit ematary, crema	ion (Nama of tory or other p	lace)	Data	20c. Location	- City or Tow	n, Stata
lity o		4 ☐ Donation 5 ☐ Othar (Specify			JOSEPH	CEMET	ERY	8/31/98	MTLLBE	ROOK. I	NY
eny Inj		21. Signature of Funaral Sarvice kicen	pe Al		22. 1	lama and Add	rass of Facility W.	ITZKE FUN	VERAL HO	MES.	INC.
5 8		St th	ull	>-				ROAD COI			
dical	ii Examiner	Immediate Ceusa (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	a. Ca b. An	Dua to (6)  Dua fo (o)	GENI( es e conseque ON r as a conseque	ince of):  140 Ca	rock rdial	infar	ct	6	hours
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thed for us	E C	Post II. Other standal and a saddle see			MATERIAL STATE OF THE STATE OF		LOS BOLL				
detached for	Physiciani	Part II. Other significant conditions co				anying causa g	pvan in Part I.				the cause of death?
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2 should be de	completed by							24a. Was perfo	an autopsy rmed?	avaii	a eutopsy findings labia prior to pletion of causa eath?
såed o	3							10	Yas 2 No	10	Yas 22 No
Partor.	DO	25. Was casa referred to medical axaminar?						eeth (Check only o	one)		
P P	9	1 Yas 2 No	Hospitai: 1 1/hpa		ER/Outpatient	SLI DOA		Homa 5□ Rasi	dance 6 □Oth	nar (Specify)	
fune fune fune fune fune fune fune fune	non:	27. Mennar of Death  1 ☑ Neturai 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Data of Ir (Month, I	njury Day Year)	28b. Tima of Injury	28c. Inj W	uryat ork? ⊒Yas 2 ⊒No	28d. Dascribe	how Injury occur	rred	
led in by the tuners	OF LITTLE	3 Suicida 6 Could not be determined	28a. Place of	Injury - At ho atc. (Spacify	oma, farm, straa			28f. Location (: City or Tox	Street and Numl vn, Stata)	ber or Rural I	Routa Number,
Madinal Carl		29a. Certifier (Check only 2 Madical Exam	sician: To the besing	st of my know	wiedga, death o	ccurred at tha	time, data and ple	ce, end due to the	causa(s) and made	annar es stei	ted.
Completely filled in by the		Giej	and mannar	sfated.							
8		29b. Signature and titia of certifiar	1.				nsa number		29d. Dafa signe		
	_	/ notell	nuen	~	MIS	1)3	4385		HUG 2	5/19	98° 1., 4021044
		30. Nama and addrass of person who o	omplated cause o	f daath (Itam	23a) (Type, Pr	int)	4	DU.	C ;		1 1111 12
Chris		Teorge J. (Trom ( 31. Dete filled (Month, Dey, Yaer)	An NO	strar's Signal	55 L/7	11e ot	ruxent	rewy,	suite 10	1,0	1. MOLIUM
State Registrar	•	AUG 3 1 1000	1	o, rui a orginal	-		,	/		,	-



6 Per 1	ID Film G762 8-31-98RC		C	ertificate o	f Death			leg. No.	4.	2000
ysician Medical	Decedent's Name (First, Middle, Last)	William	Henry	Ec	ckstein	M At		Day 20,1998		3. Time of Death 8:00 I
miner	4a Fecility Name (If not institution, give street	et end number)			4b. City, Tow	m, or Location	of Deeth	4c. County o	f Death	
	6405 Eastbourne A			v) If Under 1 Ye		dalk			ltim	
	219-10-21/3	2□ F 7. Age (#	n yrs. lest birthda Yrs.	Months Day		Min. (N	ate of Birth fonth, Dey Oril	Year) 21,1926		ace (Stete or Foreig y) yland
	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or	Location					10	d. Inside City Limits
7			C. City, Town or	Location			99 sd		10	1 DyYes 2 □ No
DILECTO	Maryland N/A	A		404 7to Oods		more Ci		I0g. Citizen of Wi	nat Count	**
	10e. Street and Number			10f. Zip Code		2.4				
	6405 Eastbourne Av	venue Wes Decedent Eve	rio II S 1	Was Decedent of	2122		es or No-	United 14. Race		
	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1110,0.	3. Was Decedent of if Yes, specify C		Puerto Rican	, etc.)		, White, e	
	15. Decedent's Education	on .	16a. De	cedent's Usuai Occ	cupation			16b. Kind of Bus		
,	(Specify only highest grede co	College (1-4or 5+)	life	cedent's Usuai Occ ve kind of work doi . DO NOT use ret	ne auring most ired)	or working				
	4 Years		I	Electrici	.an			Steel	Ind	ustry
	17. Father's Name (First, Middle, Last)						t, Middle,	Maiden Surneme	)	
	Henry W. Eckstein				Et	thel	(	unknown)		
	19a. Informent's Name/Reletionship (Type,	Print)	19b. Ma	iling Address (Stre	et end Number	r or Rurel Rou	rte Numbe	r, City or Town, S	itete, Zip	Code)
	Alvina V. Eckstein  20a. Method of Disposition  1X Buriai 2 Cremetion 3 Rem  4 Donation 5 Other (Sqecity)	ovel from State	20b. Place of Dis cemetery, c	05 Eastbo position (Neme of remetary or other p of Faith	olace)	Da	te	20c. Location - C	ity or Tov	and 2122 wn, State Maryland
	21. Signature of Funeral Service Libensee	Dem	100	22. Name and Add Duda-Ruc 7922 Wis	dress of Facility  k Funer  e Ave	ral Hon	ne of	Dundalk Marvland	, In	
	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one climmediete Ceuse (Final disease or condition resulting in death)	MYCCARD		FARCTTO					1	interval Between Onset and Death
Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e to (or es e cons	sequence of):	DISEASI	5				
200	Part li. Other significant conditions contrib	uting to death but n	ot resulting In the	underlying cause	given in Part I.		23b. Did t	obacco use con	tribute to	the cause of death
	HYPERTENSIC	W					101	fes 2□No	3 Prob	ably 4 Unknow
	TYPE 2 DIAM	BUTES M	ELLIT	US		2	24a. Was a	an autopsy med?	ava co/	re autopsy findings ilable prior to apletion of cause leath?
							1 □ Y	es 2 No	1□	Yes 2□ No
	25. Was cese referred to medical exeminer?		,			of Deeth (Chi	eck only o	ne)		
Certification: 10	- Condition	oltal: 1 ☐ Inpatient 28a. Date of injury (Month, Dey Ye	28b. Time Injur	of 28c. ir	Other: 4 Num njury at Vork?  Yes 2 1	28d. I		lence 6 Othe		)
	2 Could get be	28e. Place of Injury building, etc. (5		street, factory, office	ce	28f. L	ocation (S City or Tow	Street end Numbe m, Stete)	or Or Rure	Route Number,
edical	29a. Certifier (Check only one) Certifying Physicial Medical Exeminer:		amination end/or							
MIC	29b. Signature applittle of certifier	yal u	1		DZZ7	23		29d. Date signed		
	30. Name and address of person who comp	feted cause of death	(item 23e) (Typ	e, Print)	ELL B	LVD.	WH	ITE MA	ner	8 1 ND 423
State strar	31. Date filed (Month, Dey, Year)	32. Registrar's	Signeture	Some V.	,					

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			State of Mary		riment of t			Reg. No.	8 2	6503
Physici /Medic		Decedent's Name (First, Middle, Last     WALTER HOWA		SR.			2. Date of Dea Month	Dey 27	Vear	3. Time of Death 3:10 am
Examin		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or Lo		4c. County	of Death	
Funeral		Chaylestown  5. Social Security Number  6. Security Number	7. Age (in	enter n yrs. last birthday) Yrs.	If Under 1 Yeer Months Days		8. Dete of Birt (Month, De)	h v. Year)	9. Birthplac Country	ce (State or Foreign
Director		283-01-0574 Usual Residence of Decadent	89	) '''			MARCH	19 1909	MARYL	AND
show		10e. Stete 10b. County	10	c. City, Town or Loc	ation				10d	Inside City Limits
uth with the Maryland 23e or 28e-f show	Director	MARYLAND BALTIMOR  10e. Street end Number	E C	CATONSVILI	E 10f. Zip Code			10g. Citizen of V	What Country	1 ☐ Yes 2 ☐ No
th wit	al D	717 MAIDEN CHOICE	LANE		21228			U.S.A.		
items items	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Hispanic Origin? (Spe en, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)		e - American ck, White, etc	
5-0 72 hc	sted	15. Decadent's Edu (Specify only highest grad	ication	16a. Deced	ent's Usual Occu	petion during most of working	na	16b. Kind of Bu		stry
21 William	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ENGINE		during most of working)		UCENT I	TECHNO	LOGIES
be filed that Hygi d other event,	Bec	17. Fether's Name (First, Middle, Lest)				18. Mother's Name	(First, Middle,	Meiden Sumerr	ne)	
W 77 5 6 8	To	HARRY GARRETT				EDNA FER	GUSON			
re, Marylc s 1 and 2 should f Haaith and Mar tem 27 is marke other traumetic		19a. Informant's Name/Relationship (7)				t end Number or Rura				
daal		ELIZABETH GARRETT/ 20e. Method of Disposition				HOICE LANE	-75°	20c. Location -		
		1 Burial 2 ☐ Cremetion 3 ☐ F	ternoval from State	Ob. Place of Dispos cametery, crem			/29/			
Baltimo permit. Paga Department o Important: If any Injury or		4 Donetion 5 Other (Specify)  21. Signature of Funeral Service Licens		RUID RIDO		ess of Facility WIT	998	BALTIMO		
Ball permi Depa Impo any Ir		N. 17	P			DSON AVE C			•	
Physician /Medical Examiner	10r	23a. Part. Enter the disease, or complished, or heart failure. List only of limited the complete control of the control		Stag &						iterval Between onset and Death
Box 68760, saft certified to be executed attending physician and for use at ITP surfail transit	n/Medical Examine	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Intilated events resulting in death) Last	C	to (or as a consequ						
. 5 . 5	icla	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in the un	derlying cause gi	ven in Part I	23b Did t	obacco usa co	ntribute to ti	ne causs of death?
P.O.	y Physician/Me		initialing to death but no	A TOOURING IN THE UIT	donying cades gr	voir iii i ditti.		res 2 □Wo	717.5	bly 4 Unknown
Division of Vital Records, or Attanding Physician: The law requires I after death.  Director: After this certificate has been significate that the funeral director, page 2 should be I in by the funeral director, page 2 should be	Completed by						24a. Was perfor	an autopsy rmed?	evalla	autopsy findings able prior to pletion of cause ath?
The Last Market Andrews Page	Con						1 🗆 Y	es 2 Tho	101	res 2000
Vital I	Be	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death	(Check only o	ne)		
Phys cal did	. To	1 ☐ Yes 2 ☑ No	1 L Inpatient	2 ER/Outpetient	3LI DOA	her: 4 Nursing Hor				
Vision Attending of Attending o	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Ye	ar) 28b. Time of Injury	28c. Inju Wo M 1	rk? Yes 2 No	28d. Describe r	low injury occur	red	
Divi	Certifi	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, offica		28f. Location (5 City or Tow	Street end Numb m, Stete)	ber or Rural F	Route Number,
Divisi To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the ti estigation, in my	me, date and place, a opinion, death occurre	and due to the ded at the time, d	cause(s) and ma date and place,	anner as state and due to th	ed. ne cause(s)
To the the comp	M	29b. Signeture and title of certifier			29c. Licen	se number	1.2	29d. Date signe	d (Month, De	y, Year)
III. SERBETORI		Anches No	las MI	)	D 51	05/		AUDUST	f 27	, 1998
12		30. Name and address of person who co	empleted cause of death	(Item 23a) (Type, F	rint) hoice La	ine, cator	sville.	MI),	217-7	20
Star Registra		31. Date filed (Month, Dey, Year) AUG 3 1 199	32. Registrar's S	Signoture /	1			. ~ /		0



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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r		5. Social Sacurity Nu  212-36-( Usual Residence of I	0049	6. Se	x ⊋M 2□F	7. Age (In yr	60 Yrs.		eer It Un lays Hou	dar 24 Hrs. Irs Min.	8. Dete of Bi (Month, D March	11, 193	9. Birthplac Country 8 Maryl	ce (Steta or Forei and
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ō		Maryland	Bal:	timo	re	B	altimor	·e						1□Yes 2⊠N
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ò		1 Never Married			Armed Fe 1 Tes If Yes, Gi Year or D	2k No ive		If Yes, specify  1 ☐ Yas 2√x			Rican, etc.)		lack, Whita, etc	
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-		20e. Method of Dispo 1 Durial 2 D 4 Donetion 5	Cremation				Place of Dispo cametary, crer	metory or otha	r place)		Date	20c. Location	n - City or Towr	n, State
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The Description of the State of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death August 11:45 AM Physician Virginia Marie Guariglia 29 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (II not institution, give street end number) 4c. County of Death Examiner Fallston General Hospital Fallston Harford | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 3, 1922 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country)
Maryland 5. Social Security Number **Funeral** 1 M 2 K F 76 Yrs. 215-16-5747 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Baldwin 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 2810 Baldwin Mill Road 21013 United States 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 1000 If Yes, Give Yeer or Detes: 1 Nevar Married 2 Married 21215-0020 1 Yes 2 X No Specify: Specify: by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Savings Bank of Balto. Elementery/Secondery (0-12) College (1-4or 5+) 12 Manager altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file.
Department of Health and Mentel Hy
Important: If Item 27 is marked other
any Injury or other treumatic avent Joseph P. Manzo Clara Joyce 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Vincent J. Guariglia / Son 2810 Baldwin Mill Road Baldwin, MD 21013 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriet 2 ☐ Cremation 3 ☐ Ramovel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Park 19/2/98 Baltimore, Maryland 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Balto., MD 21214 23a. Part1. Enter the disastsa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failur. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel 1 hour ACOTE MYOCARDIAL INFARCTION disaese or condition resulting in deeth) Examiner Due to (or es e consequence of): -SEPSIS - ETIOLOGY UNCLEAR Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Lest Hyponatremia bue to (or es e consequence of Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Respiratory Depression, Rhounatoid Arthritis 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No of Vital 25. Wes casa referred to medical 88 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 100 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Albar Division 1 PNeture 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) after A 4 Homicide To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. Medical 29e, Certifier 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifian AUGUST 29, 1988 D35012 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 2 NONTH AVE. Bel Air, Md. 21014 JOHN KEVIN LYNCH MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signetura State

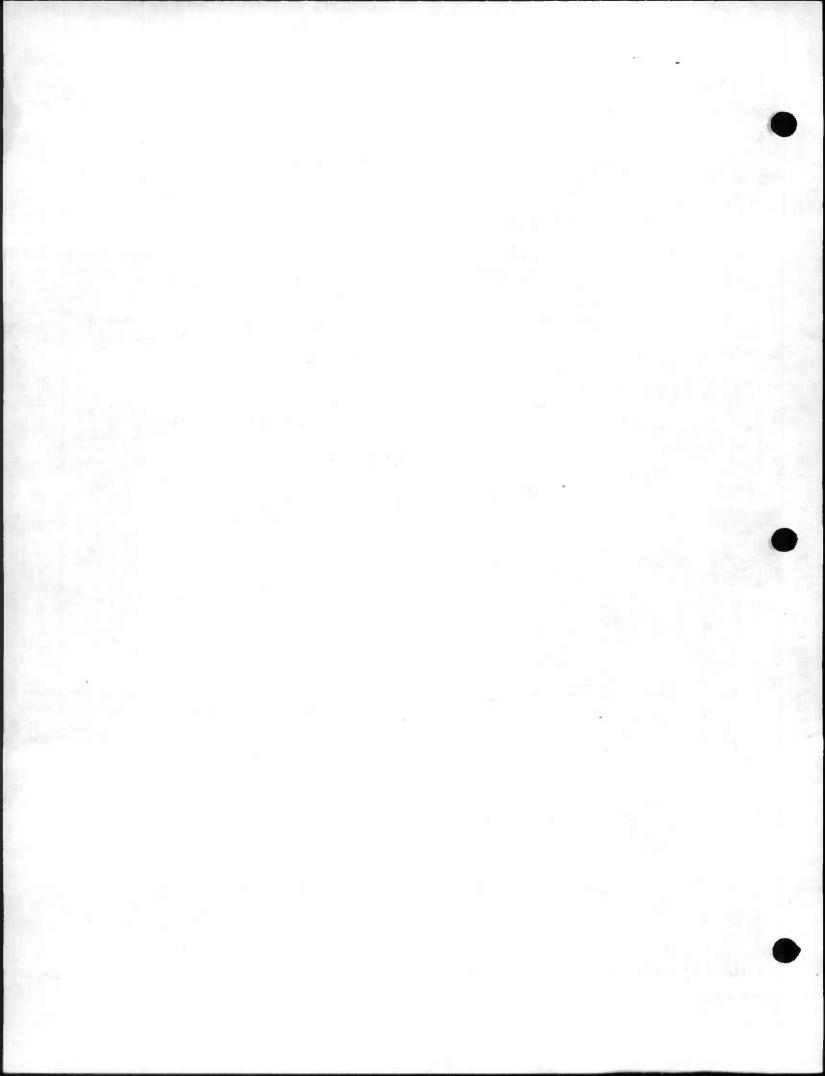
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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Daath 3. Tima of Death Day Month Yaar Physician 28 Gertrude Genco 1998 Aug. 10:45p *∉Î*Medical 4e Facility Nama (If not institution, give street and number) 4h. City. Town, or Location of Deeth 4c. County of Death Examiner Memorial Hospital Easton Talbot If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Days Months 1 M 2 F 89 Yrs. 218-66-1809 Director Jan. 22, 1909 Maryland Usual Rasidance of Deceden the Meryland 10c. City, Town or Location 10d. Inslda City I Imits 10a Stata 10b. County d 2 should be filed within 72 hours aftar death with the Merylen in and Mantel Hygiene.
7 is marked other than "natural", or flerm 23s or 28s-f show traumetic event, the Medical Exertines must be notified at 1 ☐ Yes 2X No Directo Maryland Queen Anne's Stevensville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda United States 206 Mallard Drive 21666 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give 14. Rece - Amarican Indian, Black, White, etc. 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 1 Naver Married 2 Married 1 Yas 2 No Specify: Specify: White P 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home permit. Peges 1 and 2 should be file.
Department of Health and Mantel Hyg.
Important: if them 27 is marked other.
any injury or other traumer. 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Marian C. Gillen Joseph W. Lynch 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 206 Mallard Drive Stevensville, MD 21666 Joseph D. Genco / Son 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 X Buriat 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Gardens of Faith Cem. 9/2/98 Baltimore, Maryland 22. Nama and Addrass of Facility Leonard: J. Ruck, Inc. Funeral Home 21. Signatura of Funeral Sarvice Licansaa 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Balto., MD 21214 Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Final diseasa or condition resulting in daath) **Examiner** Examiner ntestin aconor The law requires that the death certificete be axecuted physician and Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disaasa or injury that initieted events rasulting in daath) Last Dua to (or as a consequence of): anemia Physician/Medical Due to (or es e consequence of): disease Dulmoraus houcobstudue Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the causa of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Onknown neart by 24b. Were eutopsy findings eveilabla prior to complation of cause of daath? Completed 24e. Was en eutopsy nis certificeta has b I director, paga 2 s 2/2 No 1 ☐ Yes 1 □ Yas 2 □ No or Attending Physician: 25. Was casa raferred to medical axaminar? Be 26. Place of Death (Chack only ona) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) 2 1 ☐ Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Manner of Death 28b. Tima of 28d. Dascribe how injury occurred After Natural 5 Panding Invastigation s after dea. 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Sulcide 281. Location (Street and Numbar or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide To the Hospital or within 24 hours aft To the Funerel DI completaly filled in 29a. Certifier (Check only one) 15 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the causa(s) and menner es stated.
2 Medical Examtner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at tha tima, deta end place, end due to the cause(s) end manner stated. Medical 29d. Data signad (Month, Day, Year) 29b. Signeture and titla of certifiar 29c. Licensa number 30. Name and eddress of person who complated causa of daath (Itam 23a) (Type, Print) 2540 Centreville Road Centreville, MD 21617 Kathleen M. Hoey, M.D.

State Registra

31. Data filad (Month, Day, Yaar)

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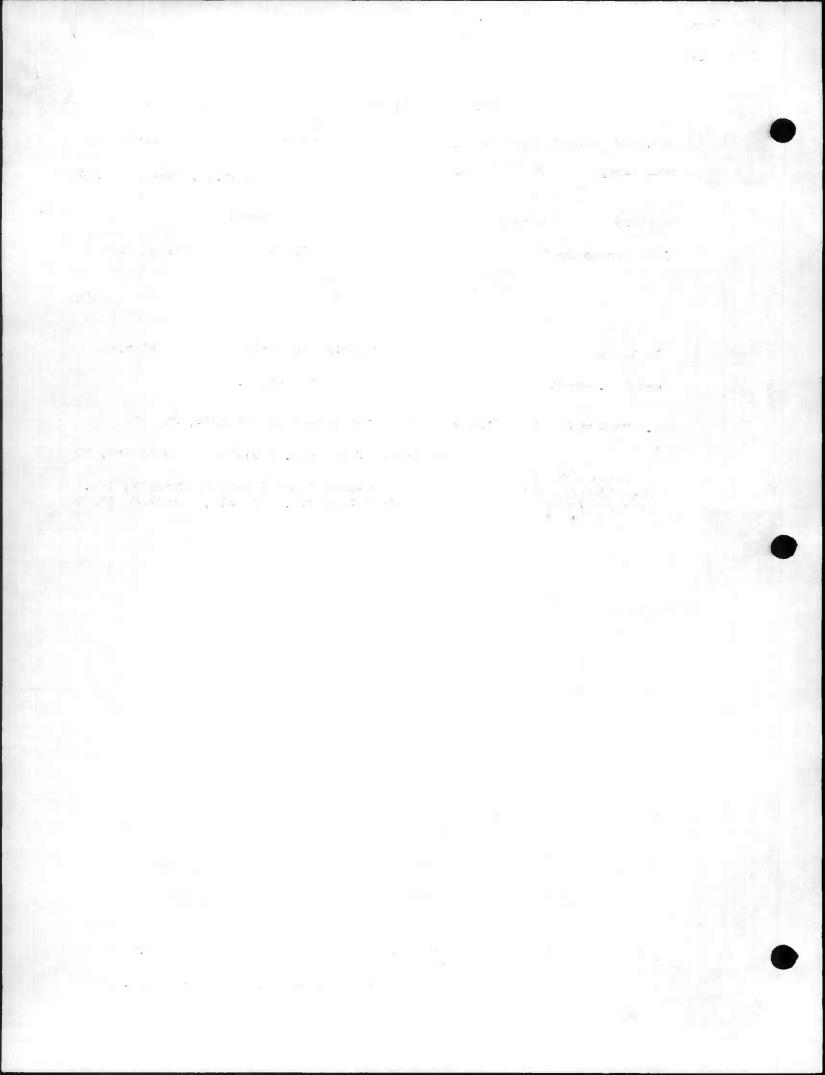
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Division of Vital Records, P.O. Box 68760,

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FALLSTON GENERAL					FALLST			RD COUN	TV
	Sex 7. A	ge (In yrs. les	t birthdey)	If Under 1 Year Months Deys	r If Under 24		rth		Stete or Foreign
219-82-2129	1 M 2 □ F	38	Yrs.	Months Deys	riours	Jan. 2		Maryl	
Usuel Residence of Decedent  10e. State 10b. County		10c. City, T	Town or Lo	cation					side City Limits
	arford	100.0.0,			Eda	ewood			Yes 21 No
Maryland H	artoru			10f. Zip Code	249	- T	10g. Citizen of N	What Country?	
2408 Papaya Roa	d				21240		United	States	
Maryland H  10e. Street end Number  2408 Papaya Roa  11. Marital Status  1 Never Married 2 Married	12. Was Deceden	t Ever in U,S.	13.	Wes Decedent of	Hispenic Origin	? (Specify Yes or N		e - American In	dien,
	Armed Forces 1 Yes 2 1 If Yes, Give			1 ☐ Yes 2 ②XNo		uerto Rican, etc.)	Specify	ck, White, etc.	
3 ☐ Widowed 4 ☑ Divorced	Year or Detes			103 20010	ороспу.			***************************************	
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Joseph F. Goge1					Theres	a E. Orr			
Joseph F. Goge1  19a. Informent's Name/Reletionship	(Type, Print)		19b. Mailir	ng Address (Stree	et end Number o	r Rurel Route Numb	ber, City or Town,	Stete, Zip Code	)
Mrs. Theresa Gog	el (Mo	ther)		9 Invert	on Road	Dundalk	, MD 2	1222	
20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removel from State	cem	etery, crer	sition (Name of netory or other pl	ace)	Date		City or Town, S	
4 Donetion 5 Other (Social		Gard	dens	of Faith	Cem. 8	/31/1998	Baltin	nore, MI	)
21. Signeture of Europa Sandiculation	Town .		22	Neme end Add	ress of Fecility	1 Home of	Dundall	c. Inc.	
EaltAK	1		7	922 Wise	Ave.	Dundalk,	Maryland		2
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Pert II. Other significant conditions	contributing to death	but not resulting	ng in the u	nderlying cause g	iven in Pert I.	23b. Dld	i tobacco use co		
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exeminer?	Hospital:	ient 2 EF	VOutpatier	nt 3 DOA	thor	ng Home 5□ Res		ner (Specify)	
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1 Naturel 5 Pending 2 Accident Investigation	on CHNKNOWN	-7 . 54.7	UNKNOW		Yes 2 No	UNKNOW	N		
27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigatic 3 Suicide 6 🖒 Could not determined	200. Pieca of it	njury - At home	e, ferm, str	eet, fectory, office	3	28f. Location City or To	(Street end Numi own, Stete)	ber or Rural Rou	ite Number,
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(Check only 2 Medical Exa	hysician: To the bes miner: On the basis	of examinetion	edge, death n end/or in	occurred at the vestigation, in my	time, dete end p opinion, deeth	lece, end due to the occurred et the time	ceuse(s) end m , date end place,	enner es steted. end due to the	ceuse(s)
29b. Signature end title of certifier	and menner s	steted.		29c Licer	nse number		29d. Date signe	d (Month. Day	Year)
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Mysh 5	Vla	de	MI		.M.E.		AUGUST	28, 19	98
30. Neme end eddress of person who	Radent	Topolin mem 2			root B	altimore,	Marria	vd 21201	
) Tranza									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1998 AUGUST 9AM GORDEN JOSEPHINE S. /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel Pasadena 143 Magothy Beach Road If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign Country)
BALT. MARYLAND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🗓 F Months Days Yrs. March 7 Director 218-07-2207 Usual Residence of Decedent the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or items 23s or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at page. 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 143 MAGOTHY BEACH ROAD Funeral 21122 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0020 If Yes, Give Year or Detes: 1 ☐ Yes 2 X No Specify: Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEHOLD HOMEMAKER 8th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) SZCZYBOR STEPHANIE ANTHONY KOROS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FRANK J. GORDEN SR. / Spouse 143 Magothy Beach Road Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cemetery8/28/98 Crownsville MD 21. Signature of Funeral Service Licentee 22. Name and Address of Facility
STALLINGS FUNERAL HOME P.A. Jr. 3111 Mountain Road Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that classed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause or a line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Allegarosu disease or condition resulting in death) Examiner Due to (or as a consequence of). Examiner that the death certificate be executed physicien and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): esn 20 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. s been signed by the should be detach 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No by 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy perlormed' has page 2 1 Yes 2 No 1 Yes 2 No certificete ivision of Vital Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 296. Signature and title of bertifier 29d. Date signed (Month, Day, Year) 29c. License number 198 MD D38958

UNNAPOLIS ROAD #106, ODENTOW MS 21113

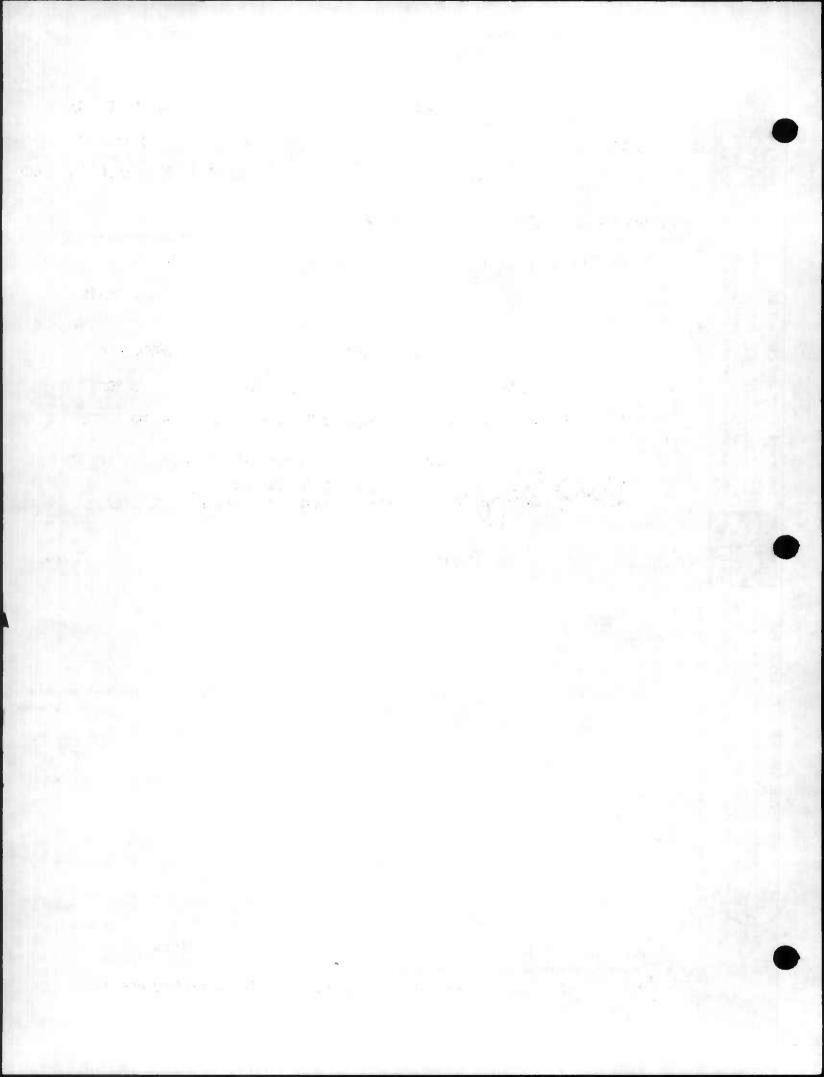
State Registrar Daliet Sing 31. Data fled (Month, Day, Yea)

AUG 3 1 1998

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

1413 32 Aegistrar's Signature

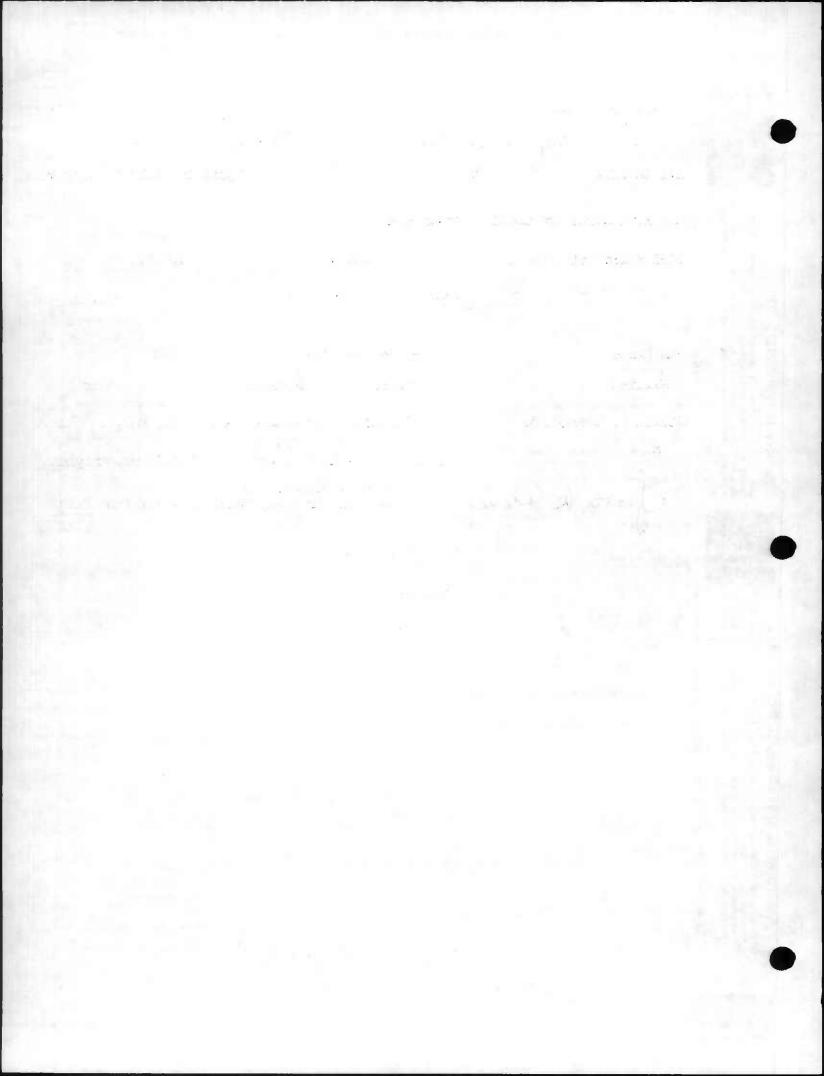
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev Yaer **Physician** 11:00 Pm Gober August 24 1998 Jeong P /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, giva street end number) Examiner Hosp: tal Raltimore 5altimore Jina. 01 Balt more If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, Year) if Undar 1 Year Birthpiece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Deys Months 12 M 2□ F 88 Yrs. 171-26-6252 Director April 10, 1910 Pennsylvania Usual Residance of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland ent of Health end Mantal Hygiane. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 XNo Maryland Baltimore County Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or itema 23a or 7131 Willowdale Avenue 21206 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ N7 / 13/48 If Yes, Give Year or Detes: 10/31/49 Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Maritel Stetus Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 PNo Specify: Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed h end Mantal Hygiane.
7 Is marked other than "natur traumatic event, traumatic event. 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant 6th Grade Army 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be William Gober Beatrice Yodis 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Itam 27 ls Stella S. Gober/Wife 7131 Willowdale Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Neme of cametery, crematory or other place) 8/27/98 Dete 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removal from Stata ortant: if I permit. Pege Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cemetery Baltimore, Maryland 22. Nama and Addrass of Facility John C. Miller, 21. Signature of Funaral Sarvice License Inc. uanita homas 6415 Belair Road, Baltimore, Maryland 21206 23a. Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiretory arrast, should or heart failure. List only one ceuse on eech line. **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner neumon i h that the death certificete be executed physicien and the burial-transit Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequance of) Rena Division of Vital Records, P.O. Box 68760. 1a Physician/Medical Dua to (or as a consequance of): attending I for use as signed by the a d be datached f 23b. Did tobecco use contribute to the cause of death? Part II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by The lew requires 24b. Were eutopsy findings aveileble prior to been s 24e. Wes en eutopsy performed? Completed completion of cause of death? Is certificete has director, pege 2 1 Yes No 1 Tes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) P 1 Yes 20 No 1 Inpatient 2 ER/Outpetient 3 DOA this 28c. Injury et Work? funeral Certification: 27. Menner of Deeth 28a. Data of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending 10⊠Naturel 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ector: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 Direc 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) AS 2402321 LK 9348 mo 30. Name and edities of person who completed cause of death (Item 23a) (Type, Print) Balt more -ine 11 MD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 1998 Registrar

**DHMH 16 Ray 6/95** 

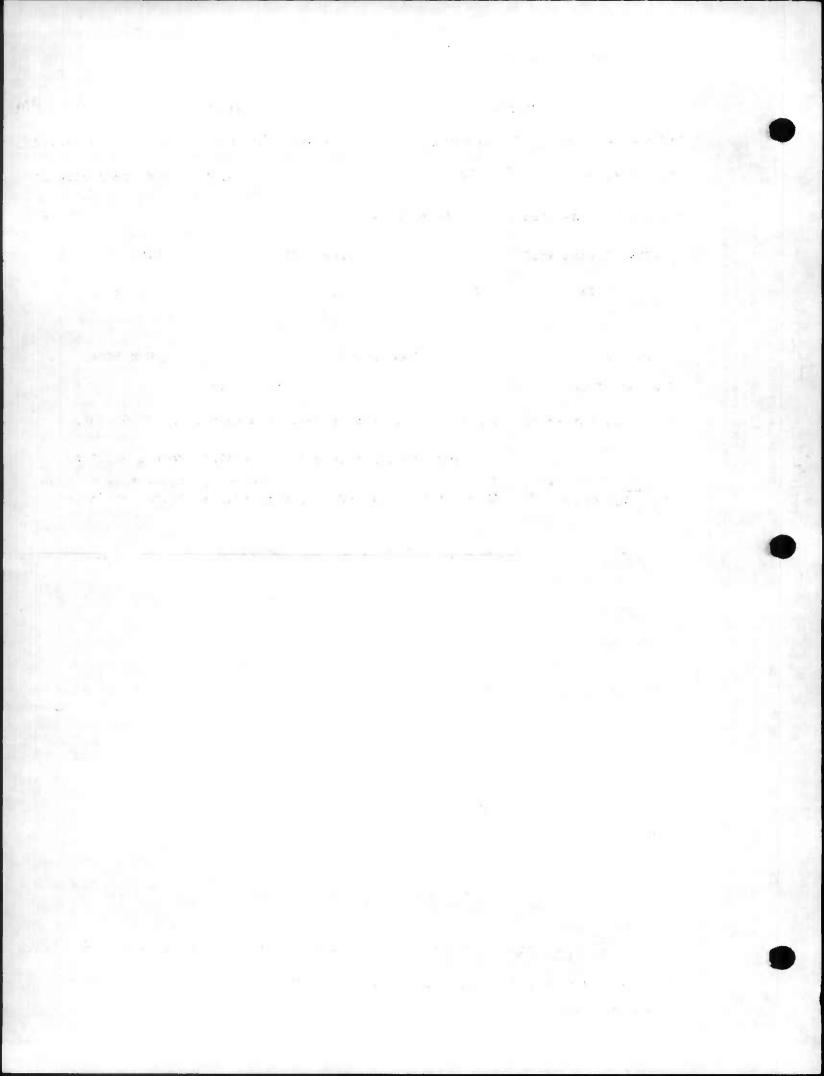


Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. Amend: #23a Part Ia,b,c Per MD Film G762 8-31-98RC Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:45 PM AUGUST 1998 Helen L. Harris /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie ANNE NORTH ARUNDEL HOSPITAL GIEN HRUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1□ M 25 F Months Deys Hours Min. Yrs. Director 209-20-4849 March 8,1926 | Pennsylvania Usual Rasidence of Deceden with the Maryland 10c. City. Town or Location 10d. inside City Limits 10a State 10b. County 7 is merked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Glen Burnie 1 Yes 200No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1334 Howard Road 21060-7405 U.S. Funeral 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Status Armed Forces' Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 3 Married 1 Yes 2 XXVo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementery/Secondery (0-12) 12th Grade Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fit I Heelth end Mental H tam 27 is marked oth Be Charles Reigh May Guerin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Heelth a important: If Itam 27 is any Injury or other tra-Gordon S. Harris Sr. /Husband 1334 Howard Road Glen Burnie, Md 21060-7405 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h tery, crematory or other place) 1 ☐ Burial 2XX remation 3 ☐ Removal from State 8/17/9\$ Towson Maryland 5 ☐ Other (Specify) Hilltop Services Corp. 4 Donation 21. Signature Funeral Service Licansee 22. Name and Address of Facility George J. Gonce Funeral Home ares ucka P.A. 4001 Ritchie Highway Balto, Md 21225 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth CEREBROVASCULAR ACCIDENT **Physician** /Medical Immediete Cause (Final RANIA 20 HOURS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner INTRACRANIAL HEMORRHAGE buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): physician a HYPERTENSION Physician/Medical Due to (or as e consequence of) 88 USB for ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed I Division of Vital Records, by 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an autopsy pege 2 1□Yes 2ਈNo 1 ☐ Yes 2 ☑ No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Lo 1 ☐mpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 -Natural after deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 4 Homicide To the Hospital of within 24 hours a To the Funeral Completaly filled 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as steled.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1998 21776 leede 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HANOVER ST BAZZIMORE 21221 MUNDRA 3001 2 MD

State Registrar 31. Date filed (Month, Day, Year)

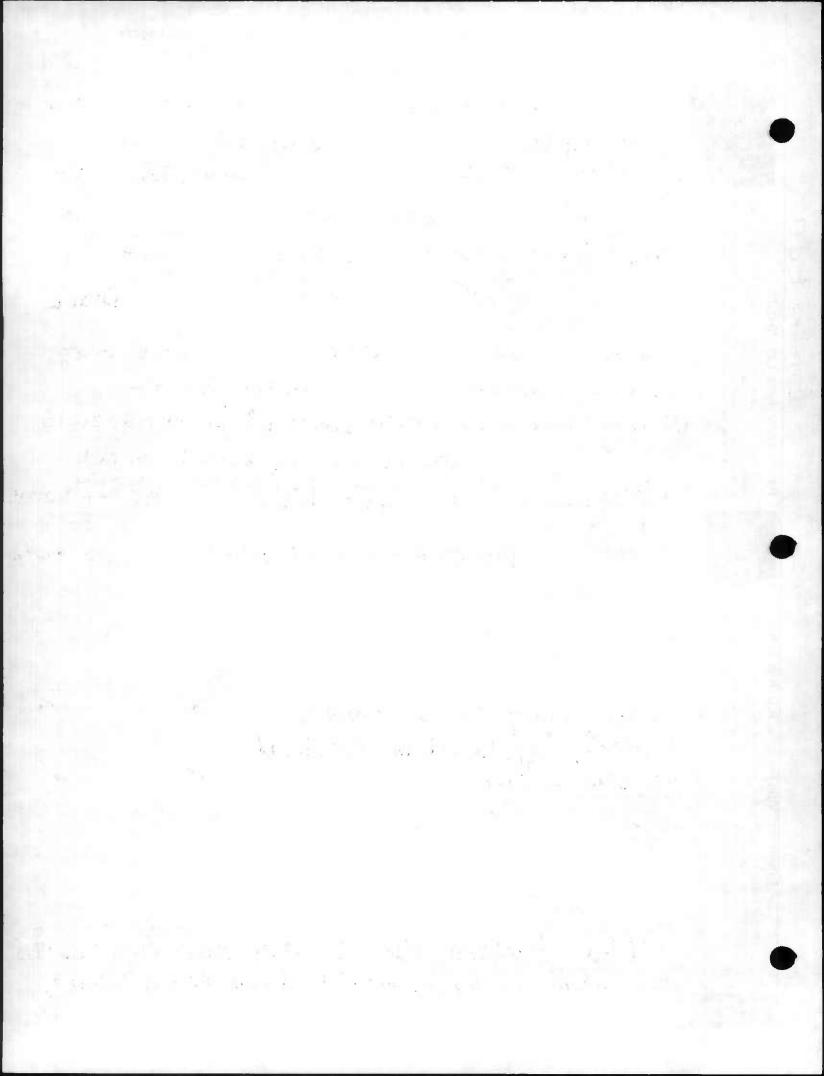
32. Registrar's Signature

Sporter



		State of Maryland / Department of Health and Certificate of Death		ene 9 g	265	
	Physician	1. Decedant's Name (First, Middla, Last)  C. A.R. C. L. D. E. H. A.R.R.L.S.	2. Data of Death Month	-	998 10	e of Death
•	/Medical Examiner Funeral Director	4a Facility Nama (If not institution, give street and number)  4b. City, Town, or  Social Security Number  6. Sex  1 Months Days Hours Mir		4c. County of 1938	9. Birthplace (Sta	ta or Foreign
1	show	Usuel Rasidence of Decedent  10e. State  10b. County  10c. City, Town or Location	)			e City Limits
1	firer deeth with the Mer r Itama 23a or 28a-f si inver must be notified funeral Director	MD NA BALTIMORE  10e. Street and Number BAREVA ROAD 10f. Zip Coda  21215	10	g. Citizan of W	hat Country?	65 2 100
020	urs a	11. Marital Status  1 □ Navar Married  3 □ Widowed 4 ☑ Divorced  12. Was Dacedant Evar in U,S.  Armed Forcas?  1 □ Yes 2 □ Mo  If Yas, Give  Yeer or Detes:  13. Was Decedant of Hispanic Orlgin? (If Yas, specify Cuben, Maxicen, Pue)  1 □ Yas 2 □ Mo Specify:	Specify Yas or No- rto Rican, atc.)	14. Raca	- Amarican Indiar c, Whita, atc.	k
121215-0020	filed within 72 ho Hygiene. rther than "naturn ant, me Medical	15. Decedant's Education (Specify only highast grada complated)  Elementary/Secondary (0-12)  Collage (1-4or 5+)  N A  16a. Decedant's Usual Occupation (Giva kind of work dona during most of w	orking ama (First, Middla, M	6b. Kind of Bu	urast	-
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Baltimore. Ma	Pages 1 end 2 s nent of Health en nt: if item 27 le r iry or other traus	Wanda Clark - Day Hace of Disposition (Name of Disposition 2 Disposition 1 Burial 2 Disposition 3 Ramoval from State	d. Bat	to. M	212 Dity or Town, State	15
Baltir	permit. Pag Depertment Important: I any injury o	21. Signature of Funaral Sarvice Licensee  22. Nama and Addrass of Facility  23a. Part I Enter the broase, or complications that caused the death. Do not antar tha mode of dying, such as cardinated the shock of heart finume. List only one cause on each line.	eal Hor	e-Ba		L ZIZIE
9	Physician /Medical Examiner	Immediate Cause (Finel disaasa or condition rasulting in daath)  a. Puseless electrical a Dua to (or as a consequence of):	chry		Interval Onsat a	Between nd Daath
x 68760.	certificata be executed nding physician end use as the burial-trensit n/Medical Examinet	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avanits rasulting in death) Last  b. Due to (or as a consequence of):  Due to (or es e consequence of):				
D. Box	death a atten od for	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	bacco usa con	tributa to the cau	se of death?
s. P.O.	gned by the datach	coronary artery disease, diabetes	1 🗆 Yo	98 2□No	3 ☐ Probably	
Records.	been s should	mellitis, hypothyroidism, peripheral	24a. Wes a perform	ned?	24b. Wara autop eveilable pr completion of deeth?	of cause
Vital	entifica ector, Be C	exeminar?   Hospital: Other:	1 12 Ya	a)		2 12 No
ision of	using Amending Physics at or attended.  It bligger After this of each by the funeral direction. To Certification: To	27. Manney Deeth 1 Maturel 5 Pending invastigation 3 Suicide 6 Could not be	Homa 5 ☐ Rasida 28d. Dascribe ho	w injury occurr		Vumbar
AIG	ospital or income atternationally filled in by	28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)  29a. Cartifiar  1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and plants.	City or Town	, Stata)		
1	To the Hospital or within 24 hours afro to the Funeral Dir complataly filled the Medical Cert	(Check only one)  2 Medical Examiner: On the besis of axamination and/or invastigetion, in my opinion, deeth occard mannar stated.  29b. Signatura and title of cartifier  29c. License number	curred at the time, de	ate end place, e		
•		Julia Suntara MD AS 24 0232  30. Name and eddgess of parson who completed causa of daeth (Item 23e) (Type, Print)	1-43923	s Au	past 26	2,1998
6	State	Usha Sunkara, Sinai Hospifal, 2401 West Belver 31. Data filed (Month, Day, Year) 32. Registrate Signeture	dere Ava	inuly	Balture	12
	Registrar	AUG 3 1 1998 > Server B. Sparks				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene DAVID HARRINGTON ITEMS: #23 PART I, 27,28A-F PER MEO G763 9-3-98 WR. Certificate of Death

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Reg	No.	-1	U		0	J	1	4
2. Data of Daeth Month	Day		Yaar		3.	Time	of	Death

4c. County of Death

10g. Citizen of What Country?

Physician	
/Medical Examiner	
Funeral	

Director

25a-f

must be n

"natural", or items in

the Medical

7 is marked other traumatic event.

Pages 1 and 2 should be fit ment of Health and Mental Hy lant; if them 27 is marked oth lary or other traumatic even lary or other traumatic even

**Physician** 

Examine

/Medical

physician and s the burial-transit

60 ettending I for use as

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should

ils certificate has I director, page 2 s

Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifict stelly filled in by the funeral director, I

To the Hospital or A within 24 hours effer To the Funeral Direcompletely filled in b

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

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Physician/M

by

Completed

Be

Certification: To

edical

Directo

Funeral

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Completed

86

the Maryland

72 hours after

filled within

Hygiene.

Baltimore, Maryland 21215-0020

J.H.H. BAYVIEW MEDICAL CENTER E.R. 5 Social Security Number 7. Aga (In yrs. last birthday) 6 Sax 10XM 20 F 424-17-0414 Usual Rasidence of Decedan 10a State 10b. County Maryland Baltimore

David Joseph Harrington

4a Facility Name (If not institution, giva street and number)

1. Decedent's Nama (First, Middla, Last)

Yrs. Aug. 10c City Town or Location

21236

10f. Zip Code

Germany 10d. toslda City Limits 1 TYas 2X No

Birthplace (Stata or Foreign Country)

1232PM

10e. Street and Number 8517 Gradien Road

11 Marital Status

1 Navar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U,S. Armed Forcas? 1 XYas 2 No If Yas, Giva 1006 1985

30

Perry Hall

 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 XNo Spacify:

Black, Whita, etc. Specify: White

14. Race - Amarican Indien,

United States

15. Decedent's Education (Specify only highast greda completed) Elamantary/Secondary (0-12) 12

Collega (1-4or 5+)

18e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) Operating Engineer

16b. Kind of Business/Industry

17. Father's Neme (First, Middle, Last)

18. Mothar's Name (First, Middla, Maiden Surnama)

Local #25

Joseph Harrington

19e. tnformant's Name/Reletionship (Type, Print)

19b. Mailing Address (Streat and Number or Rurel Routa Number, City or Town, State, Zip Coda)

Ursula Groh

4b. City, Town, or Location of Deeth

BALTIMORE CITY

If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year)

Day

29, 1967

AUGUST 27, 1998

Mrs. Theresa Harrington / Wife 20a. Mathod of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Ramovel from Stata

20b. Place of Disposition (Nama of cematary, crematory or other place) Hilltop Service Corp.

20c. Location - City or Town, State Deta 9/1/98 Towson, Maryland

Baltimore, MD 21236

4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensae Timothy S. Harman

22. Name and Address of Facility

8517 Gradien Road

5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214

Haula

23a. Part1. Entar the disease or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or heart failure.

Immediata Causa (Final disease or condition resulting in daath)

ALCOHOL, COCAINE AND NARCOTIC INTOXICATION

Dua to (or as a consequanca of):

Dua to (or as a consaguance of)

Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last

Dua to (or es a consaguance of):

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Wara eutopsy findings aveilabla prior to complation of cause

1 X Yas 2 No

1 XYes 2 No

25. Wes casa rafarred to madical axaminar? 1∰Yas 2□ No

28a. Data of Injury (Month, Dey Year) FOUND 8-27-98 5 Pending investigation

6 Could not be determined

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28b. Time of UNKNOWN

28e. Plece of Injury - At home, farm, streat, fectory, office building, atc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 X No

Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Spacify) 28d. Describe how injury occurred UNKNOWN

28f. Location (Straat and Number or Rural Routa Number, City or Town, State) UNKNOWN

26. Piece of Deeth (Check only ona)

29a. Certifier (Check only one)

27. Menner of Deeth

1 Netural

2 Accidant 3 Suicide

4 Homicide

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signetura end titla of certifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

O.C.M.E.

AUGUST 28, 1998

30. Name and eddrass of person who complated cause of death (Itam 23a) (Type, Print)

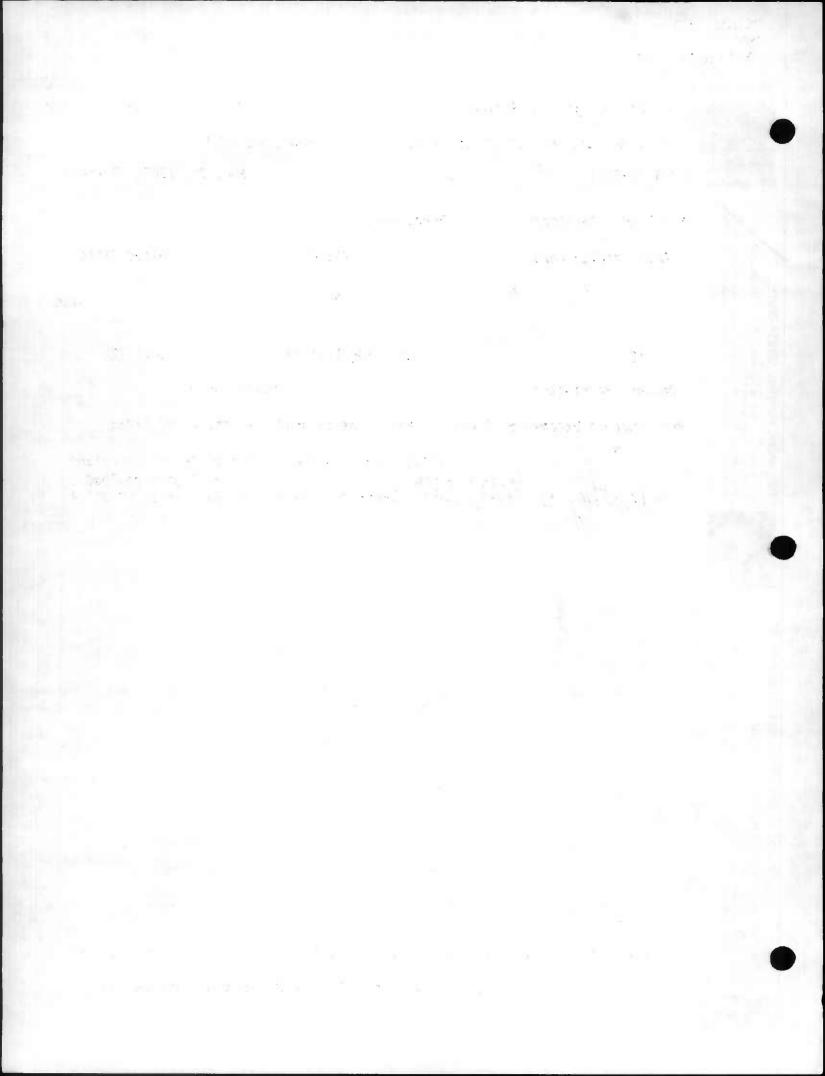
Stephen S.
31. Data filed (Month, Day, Year) MP 111 Penn Street, Baltimore, Maryland 21201 Radentz 32. Registra's Signature

UNKNOWN

State Registrar

AUG 3 1

oaks



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima ol Death Day **Physician** Month August 28, 1998 Ruth Α. Harrington 5:21 AM /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Genesis Elder Care Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Months Days Hours 10 M 2 F 89 Yrs. 218-34-1507 Director June 29, 1909 Maryland Usual Rasidence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d Inside City Limits raif, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yas 2 ♥ No Maryland Anne Arundel Pasadena Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8475 Country Life Road 21122 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, etc. 'natural', or items permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hyglene. Important: If Item 27 le marked other than "natural", or ther any injury or other traumatic event, the Medical Examinations. 1 ☐ Yes 2 X No If Yas, Giva 1 Never Married 2 Married altimore, Maryland 21215-0020 specify: White 1 ☐ Yas 2 No Specify: Py 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Cafeteria Worker 17, Father's Nama (First, Middle, Last) 18. Molhar's Nama (First, Middla, Maidan Surnama) Be Charles Wiebe Alice McCabe 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 8375 Country Life Road, Pasadena, MD 21122 George Harrington - Son 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 D Burial 2 Cremation 3 Removal Irom States 4 Donation 5 Other (Specify) Meadowridge Cemetery Aug 31 Baltimore, Maryland 21. Signature of Foheral Service License 22. Nama and Addrass of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Approximata Interval Batween Onset and Death Do not enter tha mode of dying, such as cardiac or raspiratory arrest, **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ua lo (or es e consequence of) pertension Box 68760 Physician/Medical Due Ip (or as e consequence of): mema Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 ☐ Yes 2 ☐ No þ 24b. Wara autopsy lindings available prior to 24a. Wes en autopsy performed? completion of cause of death?

Completed 1 Tas

3 Probably 4 Unknown

1 ☐ Yas 2 ☐ No

25. Was case referred to medical axaminer? 26. Placa of Death (Check only ona) Other: Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Data of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, larm, streel, factory, office building, atc. (Specify)

551

who completed cause of death (Item 23a) (Type, Plint)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Nedical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation

6 Could not be

29c. License numbe

29d. Date signed (Month, Day, Year)

31. Data filed (Month, Day, Year)

32 Registrar's Signatura AUG 3 1 1998

MID

State Registrar

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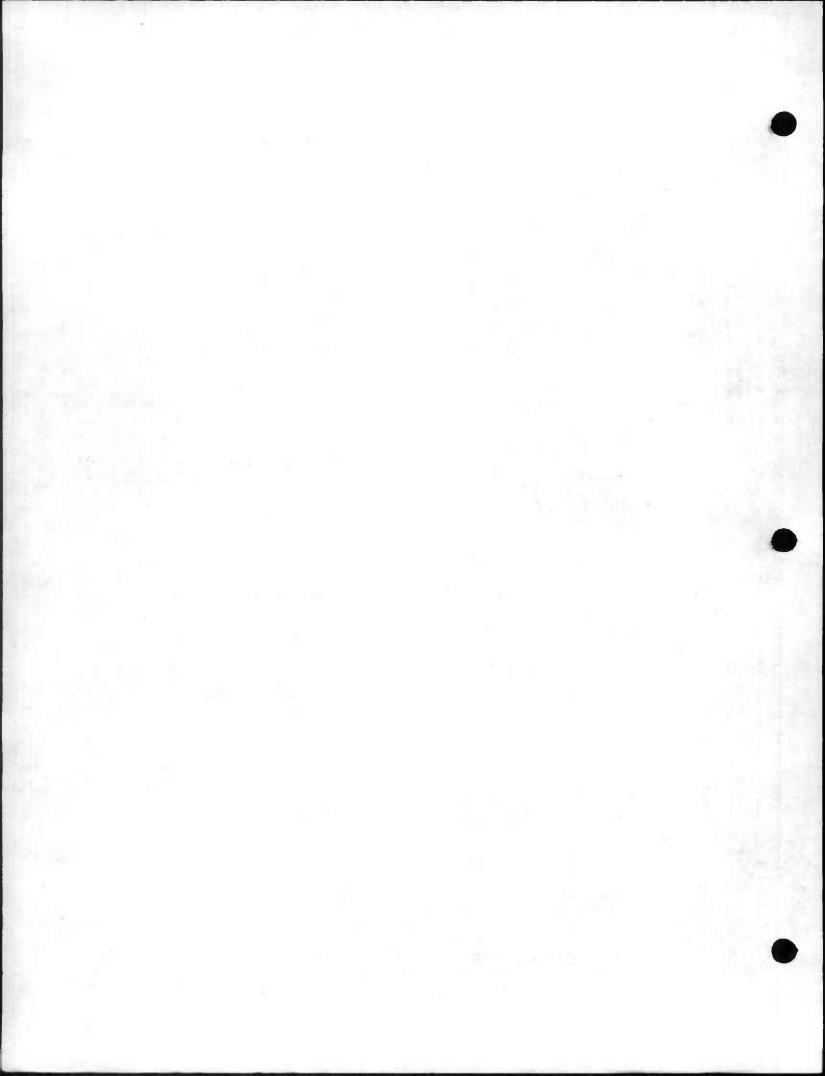
Certification: To

Medical

**DHMH 16 Rev 6/95** 

within 2 To the F

Vital



	Plea					delible Inlartment of						96611
					Cei	rtificate of	Death			Reg. No.	J. U	26514
1. Decedent's Name	(First, Middle	e, Last)							2. Dete of De	ath		3. Time of Death
MARGA	RET				MIL	LER			Month	Dey	Year	10.55
4a. Facility Neme (If		, giva street e	nd numbar)				4b. City, Tow	n, or L	August		1998 unty of Deeth	10:55 am
STELLA	MARIS	HOSPIC	E				COCK	EYS	SVILLE		BALTI	MORE
5. Social Security Nu	ımber	6. Sex		e (In yrs. lest	birthday)	If Under 1 Yaa			8. Date of Bir	th V	9. Birth	plece (State or Foreign
212-09-85	75	1□M 2	ХF	85	Yrs.	Months Dey	s Hours	Min.	(Month, Da			IARYT AND
Usual Residence of I									12/22/	1212		ZAICLEPAND
10e. State	10b. County	mTMODY:		10c. City, To	own or Lo		CA CONTOX	, T T				10d. Inside City Limits
MD	BAL	TIMORE					CATONSV	اسللا	ıt:			1 □ Yas 2XXVo
10e. Street and Num						10f. Zip Code				10g. Citizen		intry?
408 SOU	TH ROL	LING R	OAD			2	1228			Ţ	J.S.A.	
11. Maritel Status			s Decedent ined Forces?	Evar in U,S.	13.	Was Decedent of f Yes, specify Cu	Hispenic Origi	n? (Sp	pecify Yes or No	- 14.1	Race - Amer Bleck, White	
1 Never Marrie	d 2 Marr	led 1 🗆	Yes 2 X Nes, Give	lo		1 ☐ Yes 2 🔯 No		ruent	riioan, etc.)			
3 ₩ Widowed 4	Divorced	Yes	ar or Dates:			100 200	э эрвспу.			Spe	ecify: WH	ITE
(Specif	15. Decedent	s Education	leted)	16	Sa. Deced	dent's Usuel Occi	upetion e during most o	of worl	kina	16b. Kind o	f Business/I	ndustry
Elementary/Secon		1	lege (1-4or 5			kind of work don DO NOT use retir						
12				5	SECRE	TARY/ B					IATION	
17. Fether's Neme (F									na (First, Middle, HINE (F	Maiden Sun AISER		
19a. Informent's Nar	me/Relations	hlp (Type, Prir	nt)	1:	9b. Mailir	ng Address (Stree	et end Number	or Ru	rel Route Numbe	er, City or To	wn, Stete, Z	ip Code)
CAROLE	CRIST	(DAUGH	TER)		236	ROLLING	BROOK W	ΙΑΥ	CATONS	VILLE	, MD 2	1228
20a. Method of Dispo						sition (Neme of natory or other pi	lece l		Date	20c. Location	on - City or T	own, State
1 Donetion 5			I from State			ARK CEME		1 5	3/31/98	BALT	TMODE	MARYLAND
21. Signatura 🕻 Fun				LOOL		. Nama and Add						
Stone	le L	Ler	nmer		16	30 EDMO	NDSON A		ITZKE FU CATONS			
23a. Peri 1. Enter the shock, or heert Immediate Ceuse (F disease or condition resulting in death)	failure. List	only one ceus	e on eech lin	the death. Die.  IMERS Due to (or es	DIS	EASE	/Ing, such es co	erdiac	or respiretory e	rrest,		Approximete Intervel Between Onset end Death
		b		D								
Sequentially list condition any, leeding to immoduse. Enter Underliceuse (Disease or in	nediate ving	C		Due to (or es	e conseq	uence or):						
thet initieted events rasulting in daath) La	ast			Dua to (or es	a conseq	uance of):						
		d									į	
											1	
Part II. Other signific	ent conditio	ns contributin	g to death bu	it not rasulting	in the ur	ndarlying ceuse g	iven in Pert I.			tobecco use Yes 2□N		to the cause of death?  obably 4Ki Unknown
								Ţ	24a. Wes	an autopsy med?	9	Vara autopsy findings veileble prior to completion of ceusa
									10	Yes 2.DXN	0	deeth?
25. Wes case referre	d to medical						26. Plece o	of Deer	th (Check only o	ne)		
1 Yes 2 N	lo	Hospital	1 ☐ Inpetie	nt 2 ER/0	Outpetien	t 3□ DOA O	ther: 4 Nurs	ing Ho	ome 5 Resid	dence 6X	Other (Spec	MOSPICE
27. Menner of Death 1 ₩ Naturel 2 □ Accident	5 Pending	9	Dete of Injur (Month, Dey	Yeer) 28b	. Time of Injury	W	uryet ork? ⊒Yes 2 □ No	0	28d. Describe I			
3 ☐ Suicide 4 ☐ Homicide	6 Could n determi		Plece of Injubuilding, etc	ry - At home, . (Specify)	farm, str	eet, factory, office	)		28f. Location (S City or Tox		imber or Rui	rel Route Number,

**Examiner** end Division of Vital Records, P.O. Box 68760. Physician/Medical To the Hospital or Attanding Physician: The law requires that the death certified within & hours eiter death.

To the Funeral Director: After this certificate hes been signed by the ettency one completely filled in by the funeral director, page 2 should be deteched for use. is certificate has been signed by the ettend director, page 2 should be deteched for use Be Completed by Medical Certification: To

3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and

**Physician** 

/Medical

**Examiner** 

**Funeral** Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic evant, the Medical Examinal must be notified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

2

Examiner

1X Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner steted.

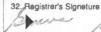
29d. Date signed (Month, Day, Year) 6.28.

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

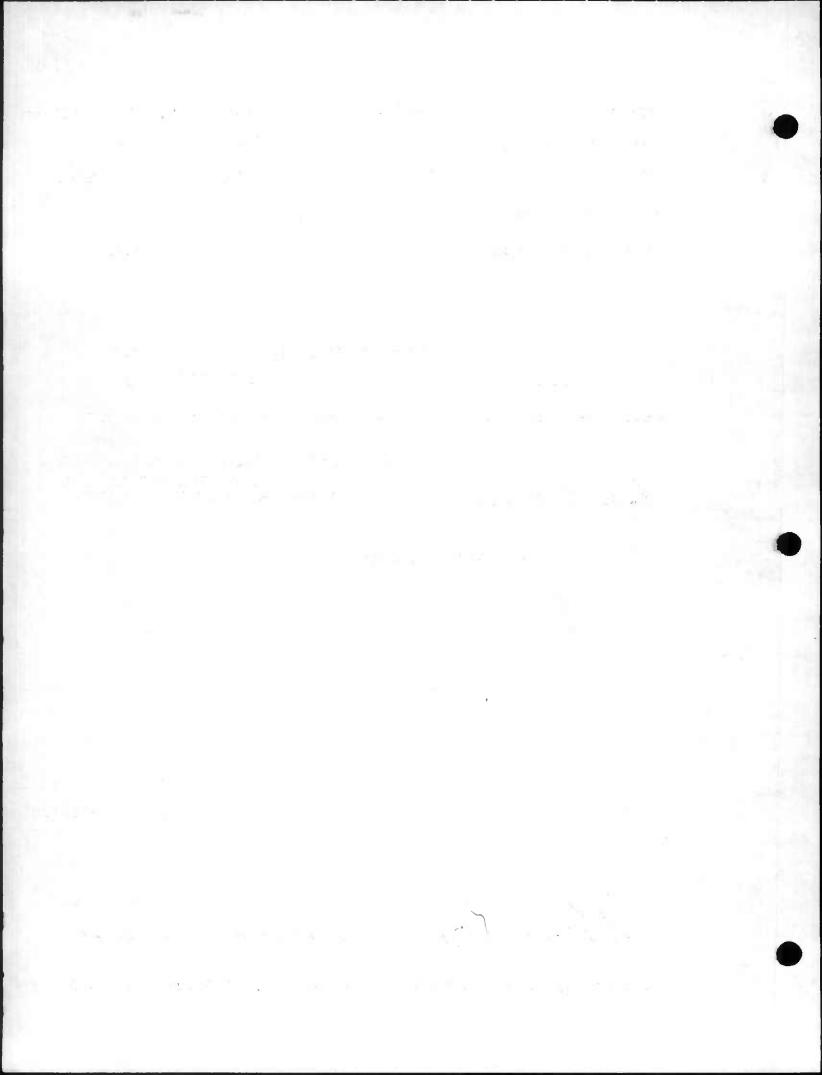
DR. EDDIE NAKHUDA, 2300 DULANEY VALLEY RD., TIMONIUM, MD 21093

31. Date filed (Month, Day, Year) State

AUG 3 1 1998



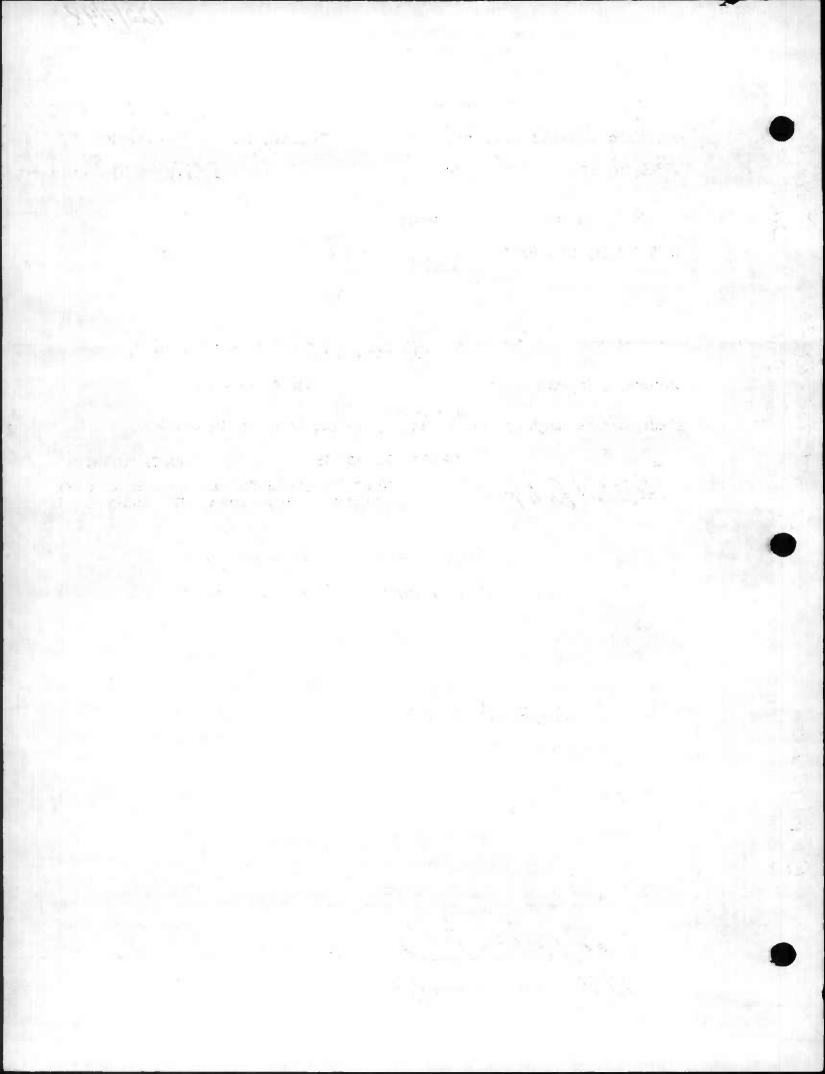
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #20b Per WVU Anatomy Board, 24a, 25, 26, 27 Per MD Film G762 8-31-98RC Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Dete of Death 3. Time of Deeth **Physician** 4b. City, Town, or Location of Deeth 0001 20 /Medical 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Atlantic General Hospital Berlin, Worcester MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
WV-Jacksonberg 7. Age (In yrs. lest birthdey) 5. Social Security Number 6. Sex **Funeral** 233-80-3042 1 M 2 F 90 Yrs. Director 86/50 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filled within 72 hours effer death with the Maryle th and Mentel Hygiene.
7 is marked other than "natural", or items 23a or 28a4 show traumatic event, "a Medical Examiner must be not?" and as 1 Yes 2 No Marion Directo Fairmont 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1206 Country Club Road 26554 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Heeith and Mentel I Important: if item 27 is marked of any injury or other traumatic eve Columbus Lafayette Cross Ida Belle Siers 33 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Rt. 3, Box 84, Fairmont WV 26554

20b. Place of Disposition (Neme of cemetery, cremetory or other place) <u>Linda Summers/Daughter</u> 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 7-27-98 4 Donetion 5 □ Other (Specify) OMEGA CREMATORY MORGANTOWN, WV 22. Name end Address of Facility
West Virginia University Human Gift 21. Signature of Funeral Service Ligenses uchay Registry, Morgantown, WV 26506-9131 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner HUPDICE hysician end the burief-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Box 68760. physician Due to (or as e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the deteched signed by t 1 Yes 2 No 3 Probably 4 Unknown þ JPAI Miller 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Director: After this certificate or Attending Physician: director, 25. Wes cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) 70 Hospital: 1 ☐ Inpatient 2XX ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√XNo funerel 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 KNeturel 1 Yes 2 No 2 Accident 6 ☐ Could not be To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number 30. Neme end eddress of person who completed cayse of deeth (Item 23e) (Type, Print) throng 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature AUG Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** A. Magrogan, Sr. Robert 2:37 PM August 27, 1998 /Medical 4b. City. Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore City N/A Johns Hopkins Bayview Medical Ctr. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys 75 Yrs 215-12-7400 Director Nov. 8,1922 Maryland Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mentel Hygiane. Important: if them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Wedless Emergence. 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Dunda 1k 1 ☐ Yes 2K No Baltimore Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? United States 21222 1331 Willow Road Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Bleck, White, etc. 1 Tyes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: WWII Specify. py 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Fire Department Fire Fighter 17 Fether's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Surname) Be Theresa Schauber Edward C. Magrogan 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Wife Dundalk, Maryland 21222 1331 Willow Road Mrs. Hildegard K. Magrogan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion □ Removel from State 8/31/98 Dundalk, Maryland 4 Donetion 5 Other Sacred Ht. of Jesus Cem. cify) 21. Signature of F 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. plications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory one ceuse on eech line. Dundalk, Maryland diac or respiratory errest, **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): ettending physician for use es the buria Physician/Medical Due to (or as e consequence of): 98 signed by tha e 23b. Did tobacco uee contribute to the cause of death? Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? should I Completed 24a. Wes en eutopsy performed this certificate has ral director, page 2: 1 ☐ Yes 2 No 1 ☐ Yes 2010 Hospital or Attending Physician: 24 hours aftar death. Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☑ DOA funeral 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending Injury To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. edicai 29a, Certifier

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) tas Alle 1012

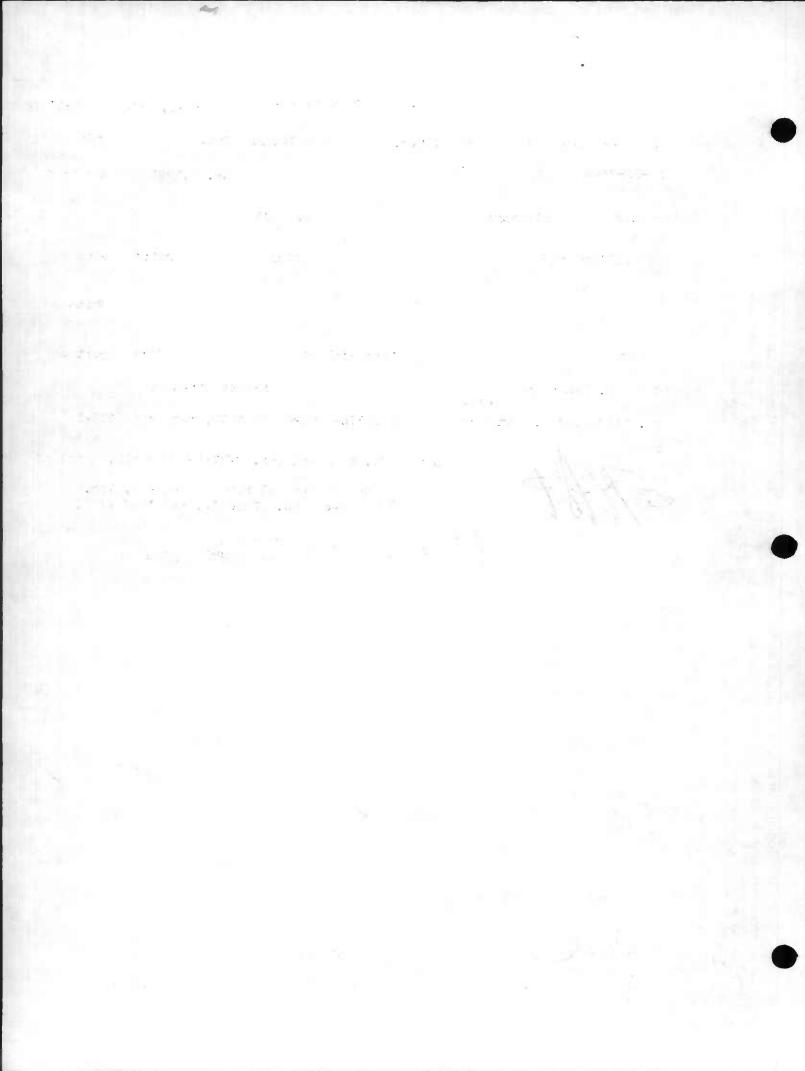
29c. License number

29d. Date signed (Month, Day, Year)

Dete filed (Month, Day, Year) State AUG 3 1 1998 Registrar

29b. Signature and title of certific

32. Registrer's Signeture



MARI IRMA of Vital ERSON Division

physicien and s the burial-transit signed by t certificate Hospital or Attending Physician: 24 hours after death. Director: 3

Physician

/Medical

Examiner

**Funeral** 

Director

r than "natural", or hams 23a or 28a-f shorthe Madical Examinar must be notified at

hours after

filed within Hygiena.

permit. Pages 1 and 2 should be filled wit Department of Health and Mantel hyghers Important: if them 27 is marked other tha any fijury or other traumatic event, the i pands.

Physician

Examiner

/Medical

altimore. Maryland 21215-0020

Directo

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in 24 hou. Other 2

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. OSTEDARTHAIMS ULERATIVE þ Completed PEPTIC ULCEN DISEASE 25. Was case referred to medical examiner?
1 Yes 2 No 8 27. Manger of Death adical Certification: Naturat 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and menner steted. 29a. Certifier 29c. License number H41069

29d. Date signed (Month, Day, Year)

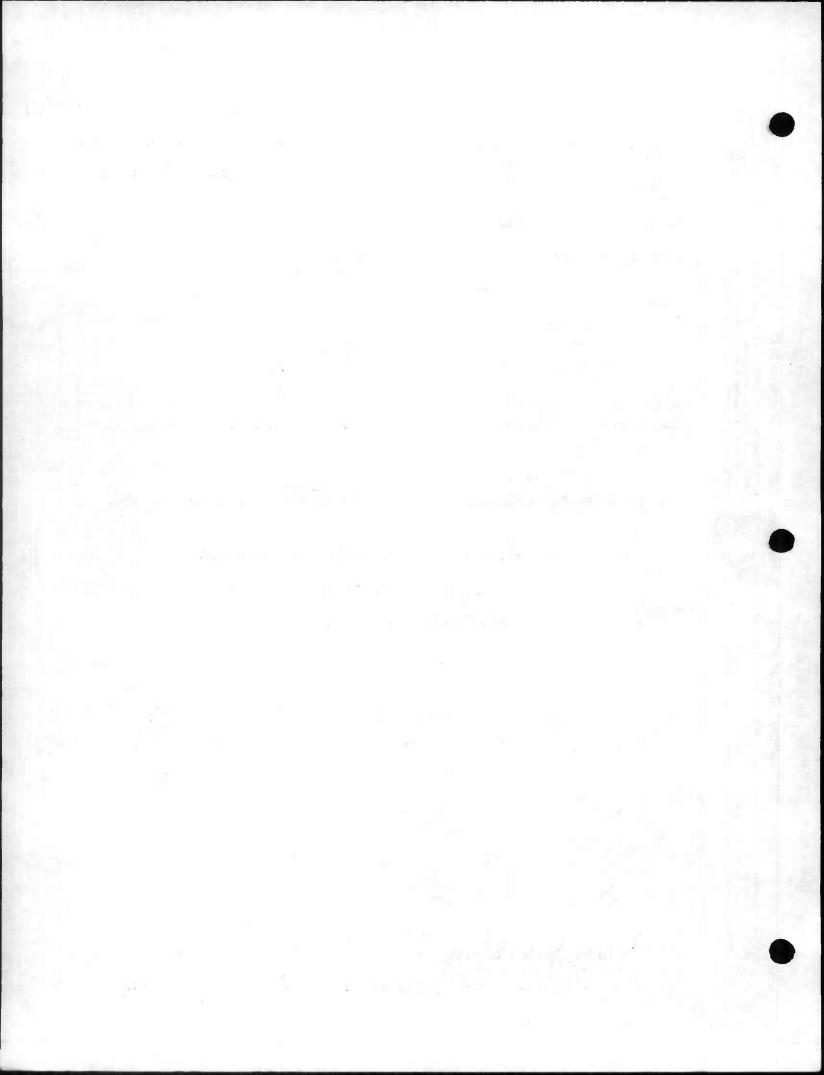
completed cause of death (Item 23a) (Type, Print)

Edgewood 21040 DR-Stanley 1308 Business enter Way 102

31. Date filed (Month, Day, Year) State AUG

32. Registrar's Signeture

Registrar **DHMH 16 Rev 6/95** 



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth AUG. **Physician** GLADYS MITCHELL 27.1998 /Medical 4e. Fecility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore City Church Home Hospital N/A 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. Months Deys Hours Min. Jan. 1, 1906 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 10M 2F 214-40-4026 Director England Usual Residence of Decedent the Merylend 10a. State 10h Count 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland N/A 1 Yes 2 □ No Director Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4112 Marx Avenue 21206 U.S.A. death 12. Was Dacedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 12 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other trauments. Elementary/Secondary (0-12) 5+ Years Principal School 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumeme) Be John Mitchell Mary Gleave 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Alfred Mitchell/Brother 4112 Marx Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Oak Lawn Cemetery 8/29/98 4 ☐ Donetion 5 ☐ Other (Spacify) Baltimore, Maryland 21. Signature of Funaral Service Licensee 22. Name end Addrass of Facility
John C. Miller, Inc. uanita ( 6415 Belair Road, Baltimore, Maryland 21206 23a Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock of heart failure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final · CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Examiner Due to (or es e consequence of): ARTERIOSELBROSIS physicien end s the buriel-trensit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medical Due to (or es e consequance of): P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ₽ No Division of Vital certific 25. Wes cese referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 - EP/Outpetient 3 - DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No this To the Hospital or Attanding Pt within 24 hours effer death.
To the Funeral Director: Affer it compietely filled in by the funere 27. Manner of Death 28a. Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. Medical 29e. Certifier 29b. Signetura and title of certifier 29c. Licensa number 29d. Data signed (Month, Dey, Yaar) varemi m.g. 017322 30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print) 26mi, M. CHURCH HOSPITAL BAG, MD. 31. Date filed (Month, Dey, Year) 32. Registrer's Signature Registrar

Might I make it in an one arrangement bender

WRC Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. 98-5081-005 VINCENT C. State of Maryland / Department of Health and Mental Hygiene OCONNELL Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year **Physician** VINCENT CRAIG O CONNELL AUGUST 28, 1998 2:30 PM. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RIVER RD. AND 195 OVERPASS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 220–52–6977 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1**X** M 2□ F 50 Director 2/17/1948 MARYLAND Usual Residence of Decedent death with the Maryland r 28a-f show 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE CATONSVILLE 1 ☐ Yes ACNO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 108 OAKDALE U.S.A. 21228 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status e filed within 72 hours efter de al Hygiene. other than "natural", or item vent, the Modical Examinat Bleck, White, etc. 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE Š 3 ☐ Widowed 4 ☐ Divorced Year or Detes:VIETNAM Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) HOWARD COUNTY BOARD College (1-4or 5+) Elementary/Secondary (0-12) OF EDUCATION 5+ TEACHER/ COACH 7 is marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Hent: If them 27 in marked of VINCENT O'CONNELL DOROTHY (JONES) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) KATHLEEN O'CONNELL (WIFE) 108 OAKDALE CATONSVILLE, MD 21228 item 2. 20b. Placa of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) = 0 Department of Important: If any injury or other other 9/2/98 ELLICOTT CITY, MD ST. JOHN CEMETERY 21. Signature of Funeral Service Ligense 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. te 1630 EDMONDSON AVENUE CATONSVILLE, MD 21228 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Drowning and multiple injuries /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or as a consequenca of) Division of Vital Records, P.O. Box 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 WUnknown g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

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To the Hospi within 24 hou To the Funer completely fil

25. Wes case referred to medical 2 27. Manner of Death Certification:

edical

1XYes 2 No

1 Natural

29a. Certifier

31. Date filed Mor

2 Accident

3 Suicide 4 ☐ Homicide

5 Pending

investigation

6 Could not be

25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier

29c. License number

28c. Injury at Work?

Street ever pass - I95 and River Road; But, more Co

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year)

Subject jumped from neight

Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2□ No

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SCENE

1 Yes 2 □ No

28d. Describe how injury occurred

26. Plece of Death (Check only one)

28f

Other: 4 Nursing Home 5 Residenca 6 NOther (Specify)

O.C.M.E.

AUGUST 29, 1998

son who completed cause of death (Item 23e) (Type, Print) 2005 res

aner

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

2de. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Street everpass - I9

28b. Time of

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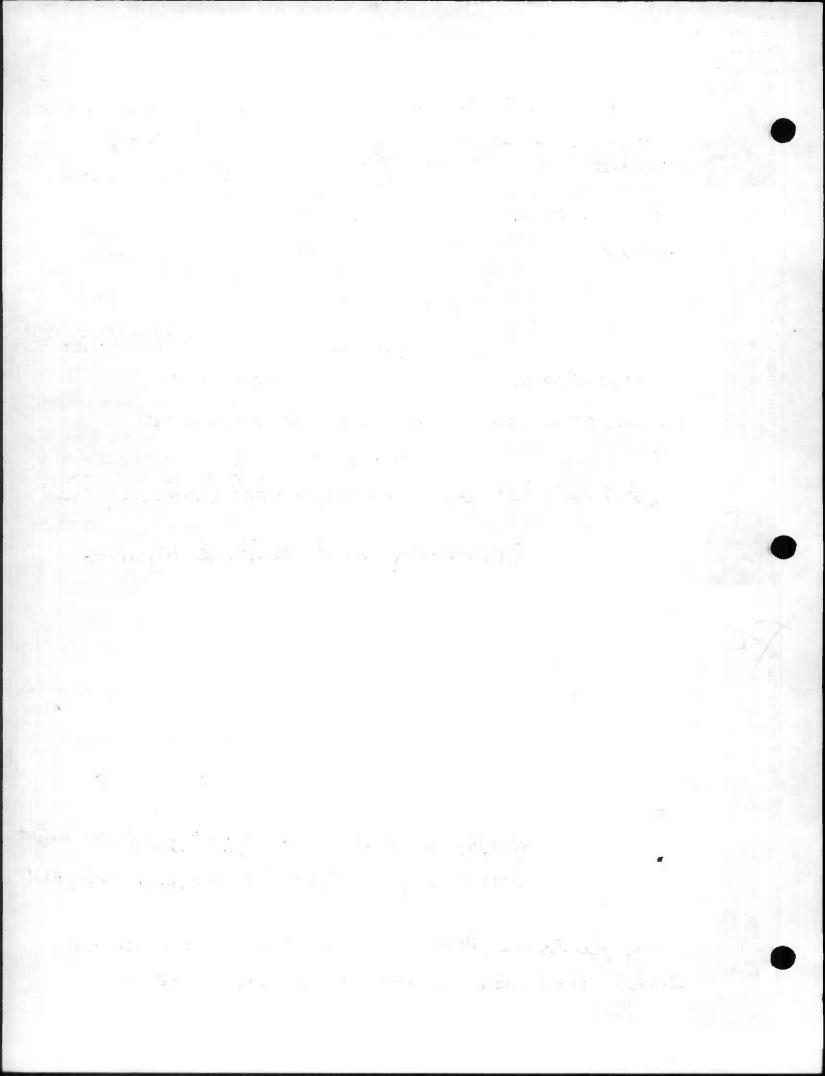
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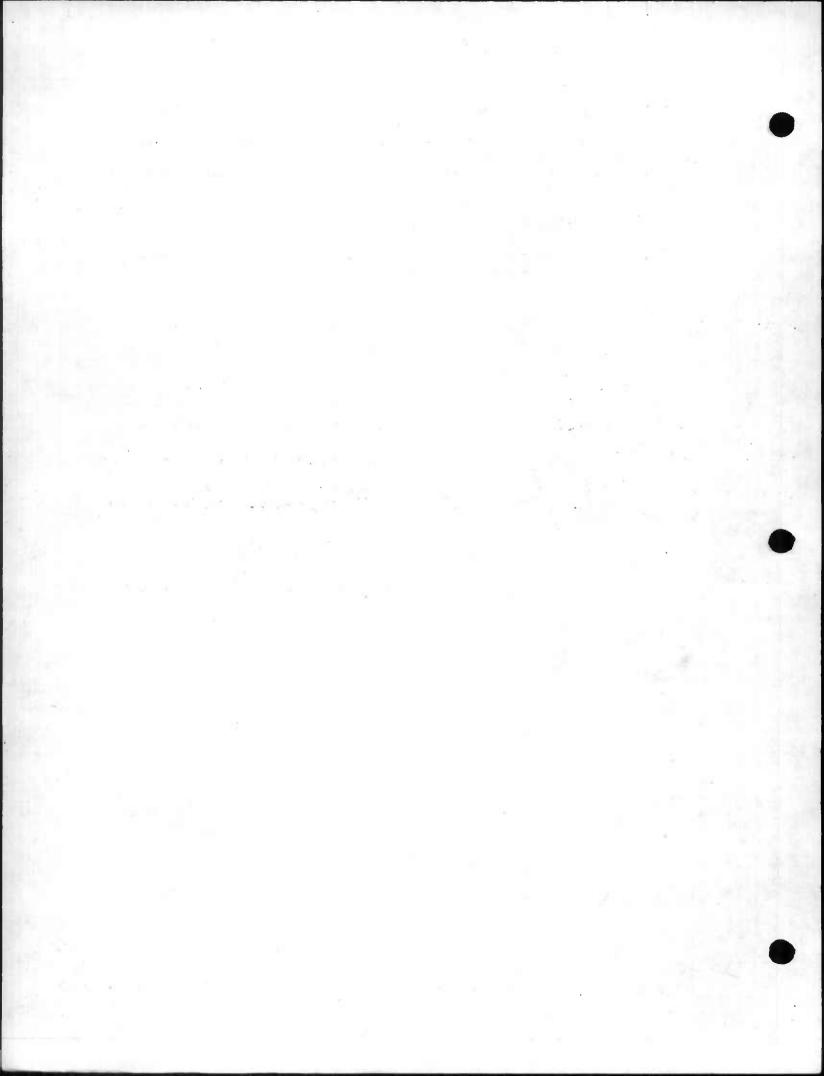
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111 Penn Street, Baltimore, Maryland 21201 32/Registrar's Signeture

State Registrar



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DIVISION O To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Macdinal Cartification:	29b. Signatura and	1 title of certifier	and maintai Sta	, with	200	Licene	e number		29d. Date signe	d (Month Day	Year)
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death August 28, 1998 **Physician** Edna May Phillips 6:10am /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Anne-Arundel Examiner Glen Burnie 823 Bentwillow Drive 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foraign Country)
 VA **Funeral** 1 M 200 86 216-09-9178 Yrs. Director November 20, 1911 Usual Rasidance of Decedant Demili. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Medical Emerican. 10a. Stata 10b County 10c. City, Town or Location 10d. fnsida City Limits Anne-Arundel Glen Burnie, Maryland 1 ☐ Yas ŽŒÑo Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21061 United States 823 Bentwillow Drive Funeral 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 22 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Biack, Whita, atc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: þ Specify. 3€Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Food Preparation Cafeteria Worker 7th Grade N/A 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Harry B. Carrier Rosie May Barton 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 823 Bentwillow Drive, Glen Burnie Maryland 21061 Eva May Cummings / Step-Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place)

Moreland Memorial Park Cem. August 31,1998 Baltimore Maryland 20a. Method of Disposition Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licansea Victor P. Doda, Jr. 22. Nama and Addrass of Facility
Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician EMPHASEMA /Medical immediata Causa (Finel 3 /11 disaasa or condition resulting in daath) Examiner Dua to (or as a consaquance of): 3 411 SUACLOTTIC STOUSSI Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaase or injury that initiated events rasulting in daath) Last and an me burial Records, P.O. Box 68760. cale be Physician/Medical Dua to (or as a consequence of): Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ă 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed b by 24b. Ware eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate 1 Yas 20000 1 ☐ Yas 2 DXX Division of Vital To the Hospital or Attending Physician: "
within 24 hours efter death.

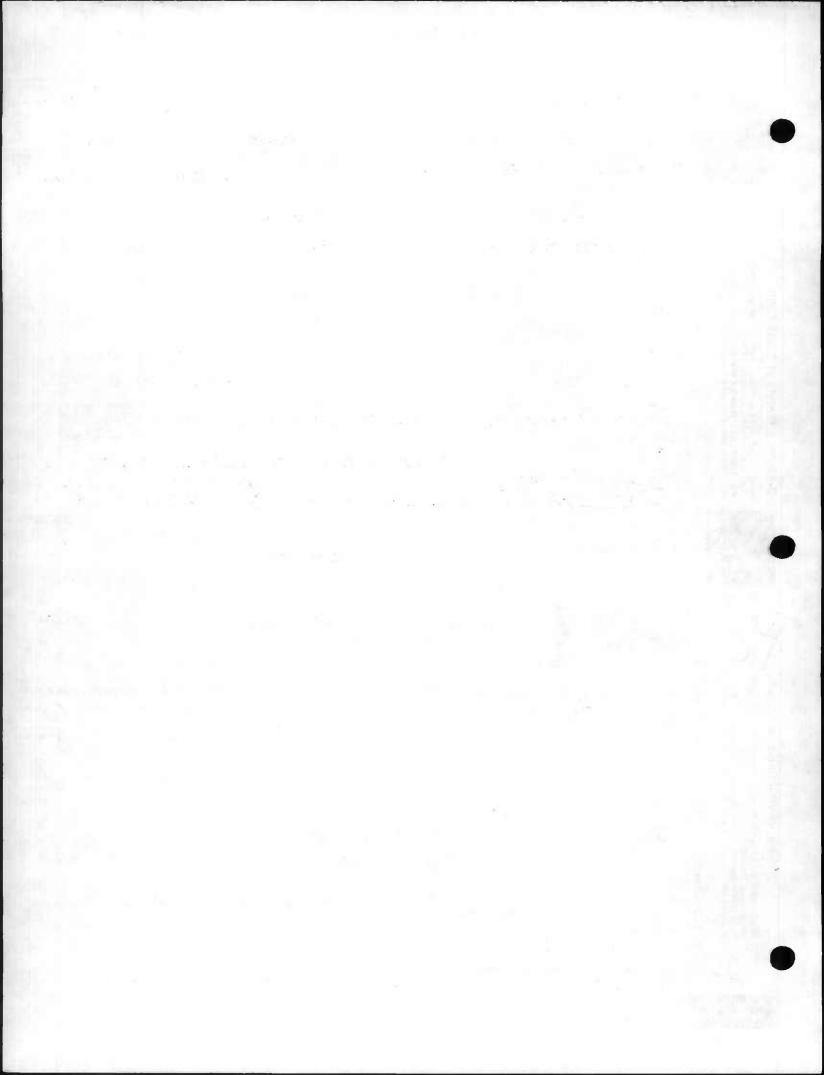
To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was casa rafarrad to medical 28. Piace of Deeth (Check only ona) Hospital: 1 npatient 2 EP/Outpatient 3 DOA Othar: 4 Nursing Homa 5 XX Nesidanca 6 Othar (Specify) 1 Yas 2XXXIo Certification: To 28a. Data of injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 1 KNatural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 3 Sulcida 6 Could not be 28a. Place of injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Cartifiar XIX Certifying Physictan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatura and title of gariller 29c. Licansa number 29d. Data signed (Month, Day, Year) ATTFNANG August 31, 1998 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) OSNER MO 1147 S. HANOVER ST MARC ٢. 31. Data filad (Month, Day, Year)

ALG 3 1 1998 \$2. Ragistrar's Signature State

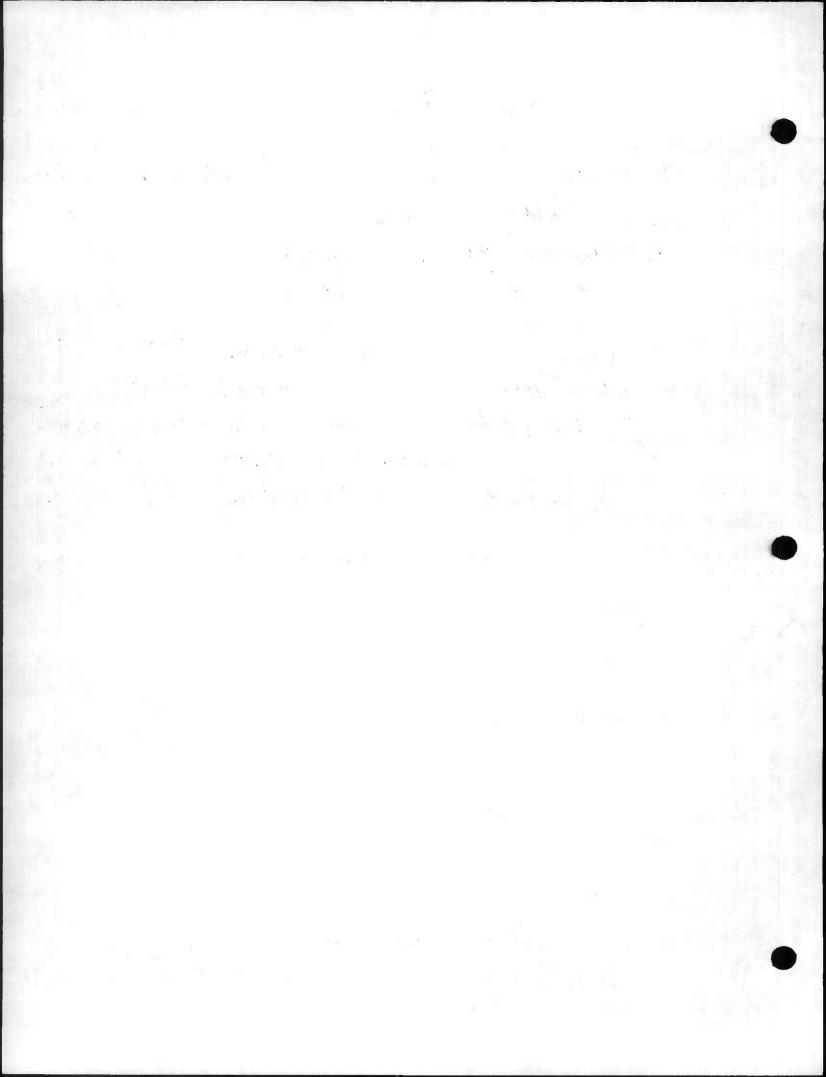
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State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	F	leg. No.	
Physician	Decedent's Name (First, Middle, Last)	1 - Par	2	2. Dete of Dee Month	Dey Yeer	3. Time of De
/Medical	Char	7es rope		flugust	29 1998	8:00
Examiner	4a Fecility Neme (If not Institution, give street end.  No Ah Aeun de   1  5. Social Security Number   6. Sex	7. Age (In yrs. lgst birthd	Glen	Burn &	Anne f	Arund place (State or Fr
Funeral Director	246-40-7544 1 M 2 F		Months Days Hours	24 Hrs. 8. Date of Birth (Month, De)	(Yeer) 1928 N.	Carolin
a-f show thred at	106. State 10b. County Marxland	10c. City, Town or Ba	thinspe			1 N Yes 2
or items 23a or 28a-f show rainst must be notified at Funeral Director	10e. Street end Number 4217 Flowerton	Rd.	10f. Zip Code 2/279		10g. Citizen of Whet Coul	ntry?
al', or items Examiner m by Fune	1 Never Married 2 Married 1 TYes,	s 2 No	13. Wes Decedent of Hispenic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☑ No Specify:		14. Reca - Americ Bleck, White, Specify:	
ygiene. nor than "natural", nt, the Medical Ex. Completed by	15. Decedent's Education (Specify only highest grade complete Elementery/Secondary (0-12) College	16a. De (G (G lif	ecedent's Usuel Occupation Give kind of work done during mosife. DO NOT use retired	t of working	Bethlehen	dustry Ste
Mental Hygi merked other attic event, I To Be Co	17. Femer's Neme (First, Middle, Last)			er's Name (First, Middle,	Maiden Sumeme)	
	19a. Informent's Name/Relationship (Type, Print)	19b. N	Mailing Address (Street end Number	er or Rural Route Numbe	r, City or Town, State, Zip	Code) ZJ
ent of Health it: If Nem 27 y or other t	20e. Method Disposition  1 Durial 2 Cremetion 3 Removal fro 4 Donetion 5 Other (Specify)	cametery	isposition (Neme of cremetory or other place)	Date Old	20c. Location-City or To DWINGS Mi	anylan own, Stete
Departmen Important: any injury pnce.	21. Signeture of Funeral Service Licansee	Ken	22. Name end Address of Fecilit 3512 Frederic	Kevin A. F. KAVE. BI	Parker Fun.	wal #
nysician Medical xaminer	Immediate Ceuse (Final disease or condition resulting in death)	Due to (or es e con		ceident		Intervel Betwee
physician and its the british transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest	Due to (or es e con				
Ng as						
the ettending phed for use as	d	death but not resulting in th	ne underlying cause given in Pert I	1. 23b. Did t	obacco use contribute t	o the cause of
igned by the ettending of the best of the as as by the best of the as as by the best of th	Pert II. Other eignificant conditions contributing to Renal Fa; lurs		ne underlying cause given in Pert I	10	res 2DNo 3□Pro	obably 4 U
is been signed by the ettending 2 should be deteched for use a pletted by Physician/M			ne underlying cause given in Pert I	1 🗆 `	res 2DNo 3□Pro	dere eutopsy find vailable prior to
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State of Maryland / Department of Health and Mental Hygiene

و الكالم			12 1 - 1	Ce	rtificate of	Death	Re	eg. No.	18	20524
Dhunio		1. Decedent's Neme (First, Middle, La	st)				2. Date of Deet Month	h Dev	Yeer	3. Time of Deeth
Physic /Medi		Marie A.	Pazourek				August		998	9:15 pm
Examin		4e. Fecility Neme (If not institution, giv	e street end number)			4b. City, Town, or	Location of Deeth	4c. Count		12122
		Stella Maris				Timoniu	ım	Balt	imor	е
Funeral Director		5. Sociel Security Number 6. S 215-48-1992 Usual Residence of Decedent	Pex 7. Age (In yrs 93	e. lest birthday, Yrs.	If Under 1 Year Months Deys			Yeer)		place (Stete or Foreign ntry) yland
fand wo		10a. State 10b. County	10c. C	ity, Town or Le	ocation				1	10d. Inside City Limits
the Marylan 28a-f show	ō	Maryland Baltimo	re T	imoniu	m					1 ☐ Yes 2√2 No
the 288	Director	10e. Street end Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
With With	0	2300 Dulanev	Valley Boad		21093					,
res 2	era	11. Marital Status	Valley Road  12. Was Decedent Ever in U	J.S. 13.		Hispenic Orlain? (	Specify Yes or No-	U.S.7		can Indien.
ified within 72 hours after death with the Manyland Hygiene. ther than "natural", or items 23a or 28a-f show out, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yes or No- rto Rican, etc.)	Ble	ck, White, ' <sup>y:</sup> Whi	etc.
72 hc	Completed	15. Decedent's Ed (Specify only highest gre		16e. Dece	dent's Usuel Occu	petion	a efector a	16b. Kind of B		
Fig.	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of world)	orking			
filed with Hygiene. ther than	NO.	6yrs.		Hom	e Maker			Own	Home	
d 2 should be filed v th and Mentel Hygie 7 Is merked other t traumetic event, ID	Be	17. Father's Neme (First, Middle, Last)				18. Mother's Na	ime (First, Middle, M	Maiden Sumer	ne)	
Went Went or rice	70	Anton Zitni	.ck			Mary	Kler	ment		
d 2 should th and Men 7 Is marks traumatic		19e. Informant's Neme/Reletionship (	Type, Print)	19b. Maili	ng Address (Stree	t end Number or F	Rurel Route Number	, City or Town	, State, Zip	Code)
permit. Peges 1 end 2 Department of Health a Important: If Item 27 It any Injury or other tra		Lawrence J. Pazour  20e. Method of Disposition  1 Burial 2 Cremation 3 C  4 Donation 5 Other (Specif.  21. Signature of Puragal Service Lices	Removal from State  // MO	Placa of Dispondentery, creest Hol	osition (Name of metory or other ple Y Redeeme 2. Name end Addro	er Cem. Sess of Facility	3/28/98	20c. Location Baltin	city or To	own, State  Maryland  rk Road
	-	23a. Pert1. Enter the disease, or con- shock, or heart feilure. List only	/angy/	R:	uck Tows	on Funera	al Home,	Inc. Tov	vson,	Md. 21204 Approximete
/Medical Examiner	Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	b. —	or es e conse						
The law requires thet the death certificate be proceed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Medicai	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last	C	or es e consec						
ras thet the death certing and by the ettending be detached for use to	Physician	Pert II. Other significant conditions of	ontributing to death but not re-	sulting in the u	inderlying cause gi	ven in Pert I.				o the cause of deeth
s their	by P							es ∠⊔ NO	0 L P10	COUNTY TO UNKNOW
na law requiras the has been signed age 2 should be on	Completed b						24a. Wes e. perform	n eutopsy ned?	ev	ere eutopsy findings ailable prior to impletion of cause deeth?
The is	EO.						1 □ Y€	s 2 No	1[	☐Yes 2☐ No
sician: The cartificate irector, pag	Be	25. Wes case referred to medical				26. Place of De	eth (Check only on	e)	1	
	0	exeminer? 1 Yes 2 1/2 No	Hospital: 1 ☐ Inpatient 2 ☐	BR/Outpetie	nt 3 DOA Ot	hor	Home 5 ☐ Reside		ner (Specif	(v)
- 5 9 8	ation: T	27. Menner of Deeth  1  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑  ↑	28a. Dete of Injury (Month, Day Year)	28b. Time o	f 28c. Inju		28d. Describe ho			,,
tal or Attendin rs eftar deeth. al Director: Af ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Speci	nome, farm, sti	reet, factory, offica		28f. Location (St. City or Town	reet end Numi n, Stete)	ber or Rura	al Route Number,
To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in b	edicai	29a. Certifier (Check only one) Certifying Ph	ysicien: To the best of my knowing of the basis of examination and menner stated.	owledge, deet ation end/or in	h occurred et the ti vestigetion, in my	me, date end plec opinion, deeth occ	e, end due to the ce urred et the time, de	euse(s) end m ete end placa,	anner es s end due to	teted. the cause(s)
with Total	2	29b. Signature and tiple of cediffer	de No		29c. Licens	1 5 5 0 4	29	9d. Date signe	ed (Month,	
6		30. Name and address of person who				110: 2:	Timon	i 11 m	Md 2	1093
Sta	te	Eddie Nakhuda 31. Dete filed (Month, Dey, Year)  AUG 3 1 1998	32. Registrer's Sign	ature	Sporks		1 I MOII.	-um, I	u 2	-023

DHMH 16 Rev 6/95

NAME: PAZOUREK, MARIE

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**Physician** /Medical Examiner

#29c

**Physician** 

/Medical

Examiner

**Funeral** 

Director

an "natural", or items 23s or 28s-f show Medical Examiner must be notified at

be filed within 72 hours efter de ntal Hygiene. Id other than "natural", or flem event, me Med cal Examper I

. Pages 1 and 2 should be file ment of Health end Mental Hyant: If Item 27 is marked oth jury or other traumatic event

permit. Page Department of Important: If I any Injury or once.

Director

Funeral

by

Completed

MD

the Meryland

with

death

Baltimore, Maryland 21215-0020

the death certificate be axecuted

physician and s the buriel-transit attending p signed by the a should b certificata has b diractor. this

Division of Vital Records. P.O. Box 68760

thet

law requires

or Attending Physician:

funaral death. aftar death Director: A

Examine Physician/Medical 2 Completed Be Certification: To

25. Was case referred to medical examiner? 2000 Hospital: 1 Inpatient 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 1 Netural

2 Accident 3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one)

5 Pending investigation 6 Could not be determined

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

29c. License number P12306

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

26. Place of Death (Check only one)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

2 PNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

2401 W. BELVEDERE AVENUE, BALTIMORE, MARYLAND 21215 JOSE BENDAYAN, MD

State Registrar

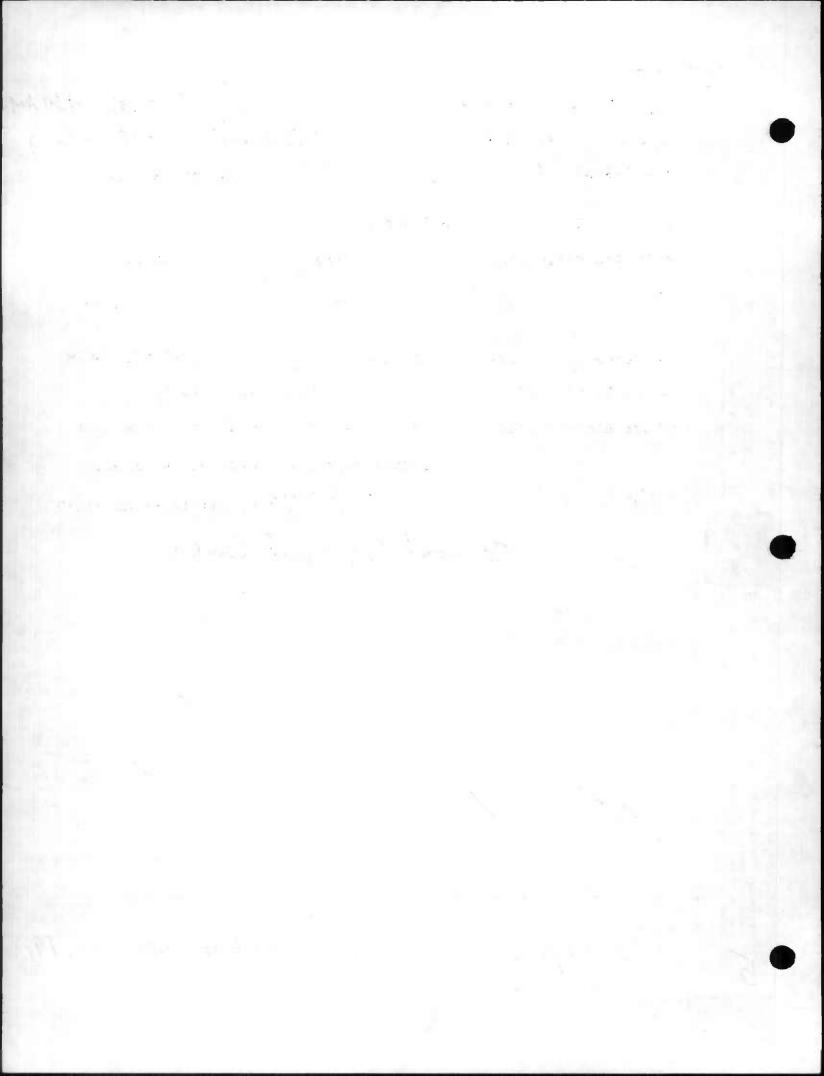
Medical

31. Dete filed (Month, Day, Year) AUG 3

29b. Signature end title of certifier

32. Registrer's Signature

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Department of	Health and	mental	Hygien
Cartificate o	f Dooth		

111 Penn Street, Baltimore, Maryland 21201

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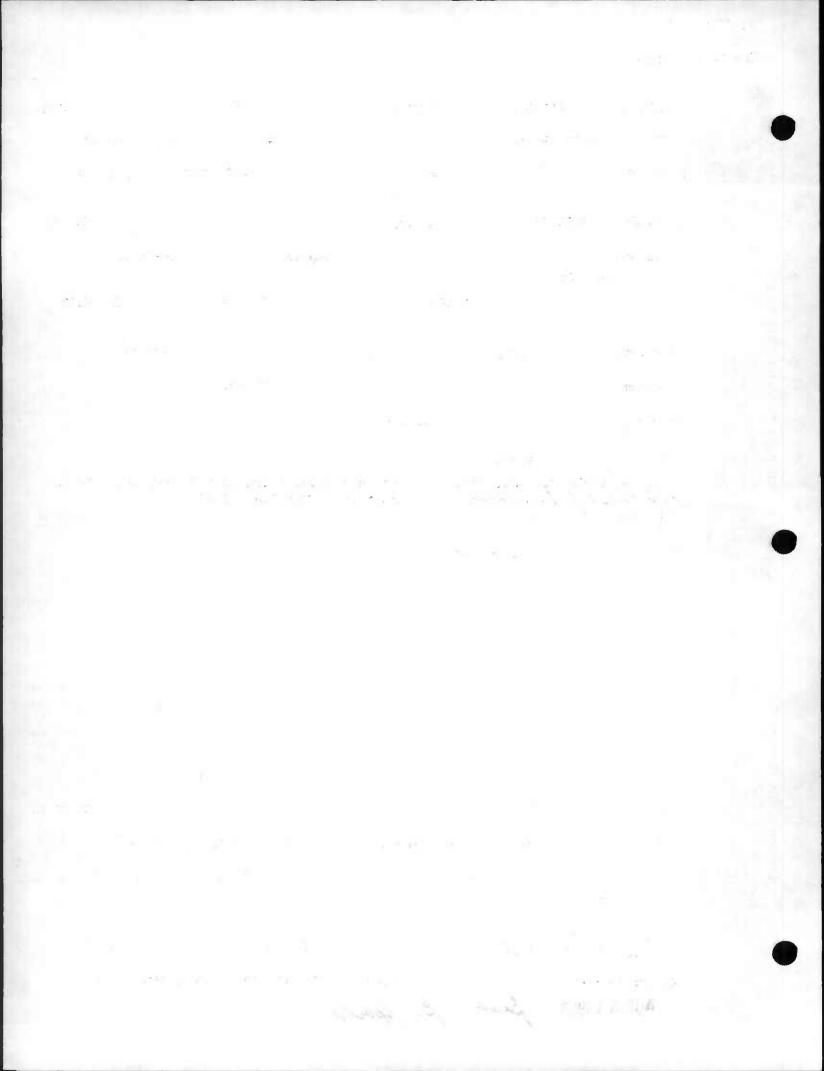
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	1. Decede	nt's Name (First, Middle,	Last)		TITES				2. Dete of Dee		Year	3. Time of Deeth
nysician Medical	CAR	LOS A	LBERTO	Q	AMIREZ				AUGUST	13, 199		1120AM
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	7801	WEST PARK	DRIVE				7	ADELPHI		PRINCE	CEO	DCEC
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al or	UNKNO	WN	1 M 2□ F		36 Yrs.	Months	Deys	Hours Min.	(Month, De) 6/7/196	_	UNKN	
		idence of Decedent							0/1/150	<u></u>	CIVILLIA	20014
	10a. State	10b. County		10c. Cit	ty, Town or L	ocation						0d. Inside City Limits
S	UNKN	DWN UNKN	OWN		UNKNO	[A][N]					Į	1□Yes 2□No JNKNOWN
Director	10e. Stree	end Number			- CATILLE O	10f. Zip C	ode			10g. Citizen of \		
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Funeral	11. Marite	Chabina	12. Wes Deced	dent Ever in U	,S. 13.	Was Decede	nt of His	NOWN penic Origin? (S	pecify Yes or No-	14. Rac	e - Americ	an Indien,
Ē	1 □ Ne	UNKNOWN ver Married 2 Marrie		2 No				, Mexican, Puert	o Hican, etc.)	Bled	ck, White,	etc.
à	3 □ W	dowed 4 Divorced	If Yes, Give Yeer or De	tes:UNKN	NWC	1 Yes 2	_l No	Specify: UNK	NOWN	Specify	HIS	PANIC
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pie	Floressi	(Specify only highest ary/Secondary (0-12)		40× 5 × )	(Give	DO NOT use	done du retired)	uning most of wor	king			
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	-	onetion 5 Other (Sp		te								
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Physician	Pert II. Oth	er significent condition	s contributing to dea	un but not res	suiting in the L	undenying cau	use give	n in Péπ I.				the cause of death?
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d by									24e Wes	en eutopsy	24b. W	ere eutopsy findings
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To	1⊠ Ye		Hospitel: 1 ☐ in	patient 2	ER/Outpatie	nt 3□ DOA	Other	r: 4 Nursing H	lome 5 Resid	lence 6 Oth	er (Specif	WAT SCENE
	27. Manne		28a. Dete of	Injury Day Year)	28b. Time o	of 28	c. Injury Work	et ?	28d. Describe h	now Injury occur	red	
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ffice	3 □ S	icide 6 Could n	ot be 28e. Plece	of Injury - At h	ome, ferm, st	treet, factory,	office		28f. Location (S	Street end Numl	ber or Run	al Route Number,
en	4 LJ H	omicide determin	building	g, etc. (Special					City or Tov		in= P	RING GORGE
a C	29a. Certif	ier 1 Certifying	Physicien: To the b			th occurred et	the time	e, dete end plece				
edical	(Checone)		xaminer: On the bes	sis of exemine								
N S		ture end title of certifier		11-11-11-11		29c.	License	number		29d. Date signe	d (Month,	Dey, Year)
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		wayne In	e your				0.	C.M.E.		AUGUST	14,	1220
	I 30 Name	and addrage of person w	to completed cause	of death (Iter	n 23a) (Tyne	Print)						

Registrar DHMH 16 Rev 6/95

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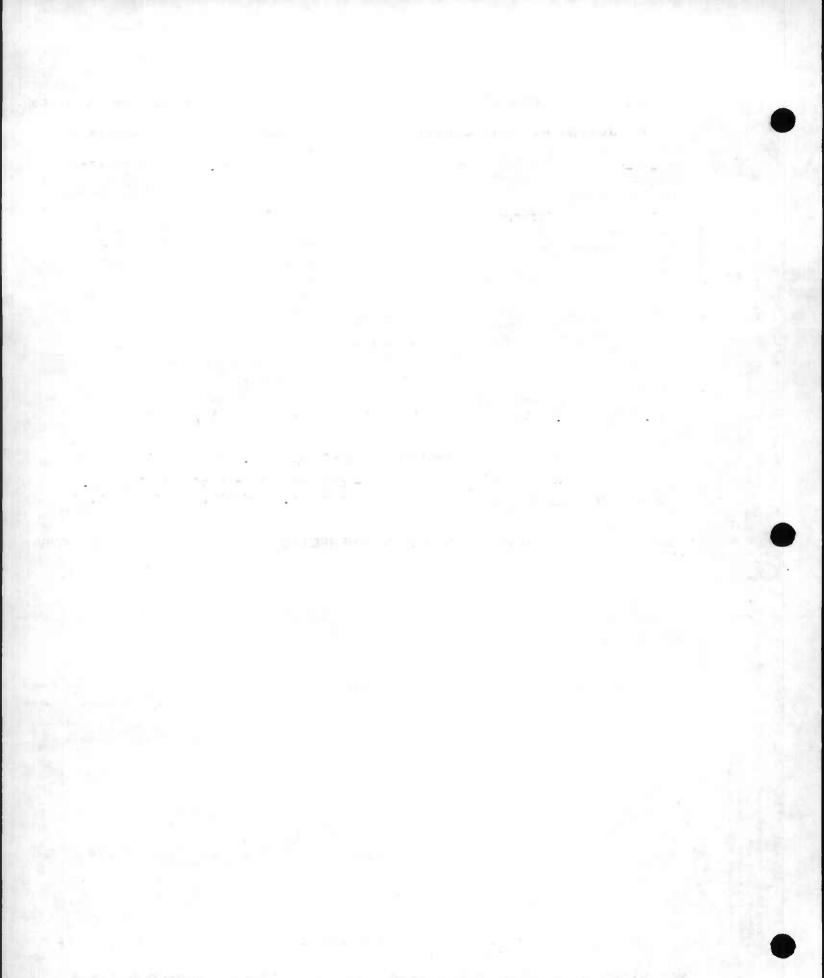
Margarita Korell M.D.

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** MARTE GERTRUDE ROTHE AUGUST 25, 1998 4:31 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 6,1906 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Funeral Months Days 1 M 28 F Maryland Yrs. 212-09-1055 Director Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show a notified at 1 ☐ Yas 2 ☑ No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or 7255 Stratton Way 21224 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yas, Giva Yaar or Datas: "natural", or It edical Examin altimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White 3€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: if fem 27 is merked other than "n any injury or other treumatic event, the Med Spice. Elementary/Secondary (0-12) 8 Years College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be 2 William Bodenburg Mary Maier 19a. Informant's Name/Ralationship (Type, Print) Daughter 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mrs. LaVerne G. Walker 8170 Del Haven Road Dundalk, Maryland 21222 20b. Place of Disposition (Nama of 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 Othar (Specify) Moreland Memorial Park Cem. 8/29/98 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland aug, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, ist only ona cause on each line. Approximata Interval Between Onsat and Death **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Immediata Causa (Finat 3 DAYS disease or condition resulting in death) Examiner Due to (or es a consequence of). Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): The law requires that the death certificate be and Box 68760, Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by i 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificate 1 ☐ Yas 2 No 1 TYes or Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yas 2 No Hospital: 1 Shpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To Chis funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending invastigation 24 hours after death. Funerel Director: A 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, tactory, office building, atc. (Specify) 2 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) D. de Leon, M.D 19508 nature dad august 26, 1998 30. Nema end addrass of person who completed cause of death (Item 23a) (Type, Print) NATIVIDAD D. deLEON, M.D., 7620 YORK ROAD TOWSON. MARYLAND 21204 31. Data tiled (Month, Dey, Year) 32. Registrar's Signatura State AUG 3 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	"	Trees	V

9. Birthplece (State or Foreign Country) ew York

White

10d. Inside City Limits 1 Ves 2□No

21214

Approximate Intervel Between Onset end Death

24b. Were eutopsy findings

1998

New

3. Time of Death

10:00 AM

	D., CO.
3altimore, Maryland 21215-0020	armit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland epartment of Health and Mental Hygiene.  sportant: If Item 27 Is marked other than "naturel", or Items 23s or 28s-4 show ny Injury or other traumatic event, tra Medical Exercities must be notified at

2. Date of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 27, August Patrick Romano /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 2820 Bauernwood Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 03-23-1905 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 18 M 2□ F Months Deys Hours Yrs. 212-09-8036 93 Usuel Residence of Decedent 10e Stete 10b. County 10c. Cltv. Town or Location Directo Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 2820 Bauernwood Avenue Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) 8 Years College (1-4or 5+) Aeronautical Machinist Bausch & Lomb 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Carmella Marotta John Roamno 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Bonnie Stein (Daughter) 51349 Old Sycamore Court Granger, Indiana 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ★ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/31/98 Hilltop Service Corp. Towson, Maryland 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. w agera J. Wayne Osterling 5305 Harford Road Baltimore, Maryland sease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, lure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, physician The law requires that the death certificate be Due to (or as e consequence of): signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

yper cholesterolemia

Hospitel:

	performed?	,	aveilable completio of deeth?	prior to on of cause	
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(C	heck only one)				
ne	5 Residenca	6 Other	(Specify)		
28d.	Describe how inju	iry occurre	d		

20.	exeminer?	od to modical
	1 ☐ Yes 2	lo
27.	Menner of Deeth	
	1 Maturel	5 Pending
	2 Accident	investig

28e. Date of Injury (Month, Dey Year) 28b. Time of investigation

28c. Injury et Work? 1 Tyes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

4 Homicide 29a. Certifier

3 ☐ Suicide

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Completed

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Certification:

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this certificate Physician:

After this

Director: A

• Funeral Dire letely titled in b Hospital

To the I within 2 To the I

or Attending

death.

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner es steted.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

(Check only one) 29b. Signature and title of cartifier

29c. License number 29d. Date signed (Month, Dey, Year)

26. Piece of Deetl

Other: 4 Nursing Hor

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

6 Could not be

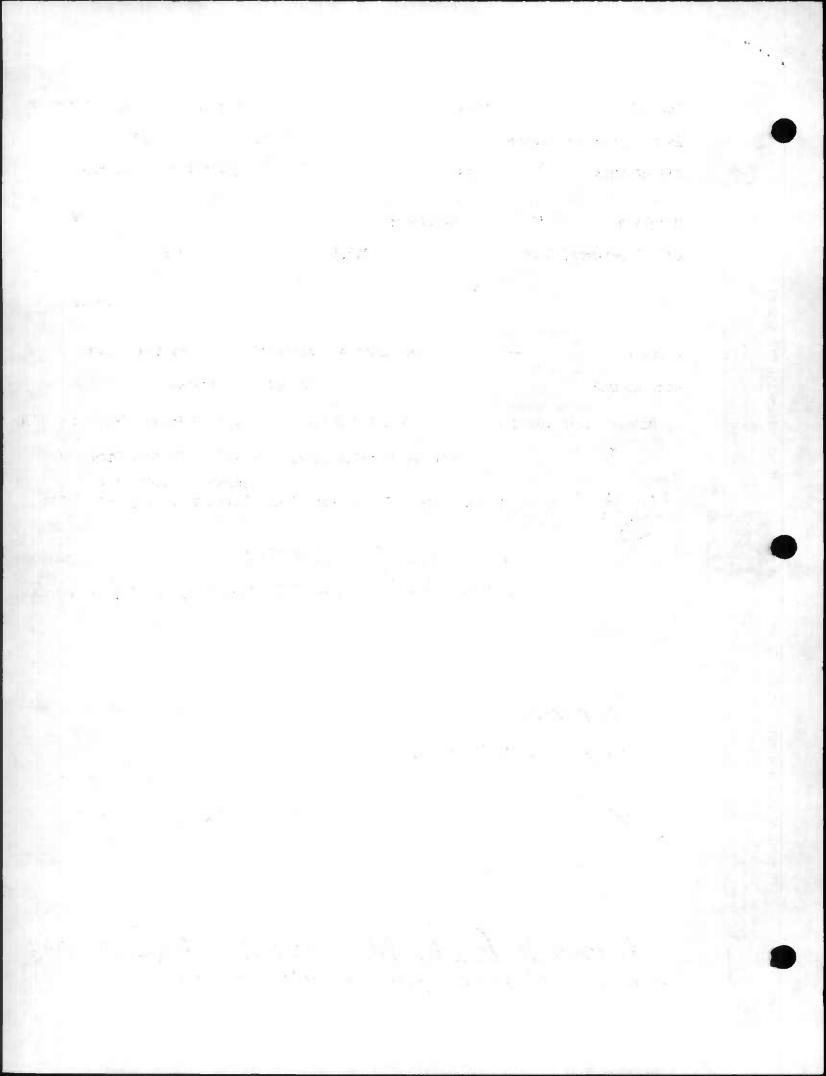
AUG 3 1 1998

State Registrar

3400 Brenms 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

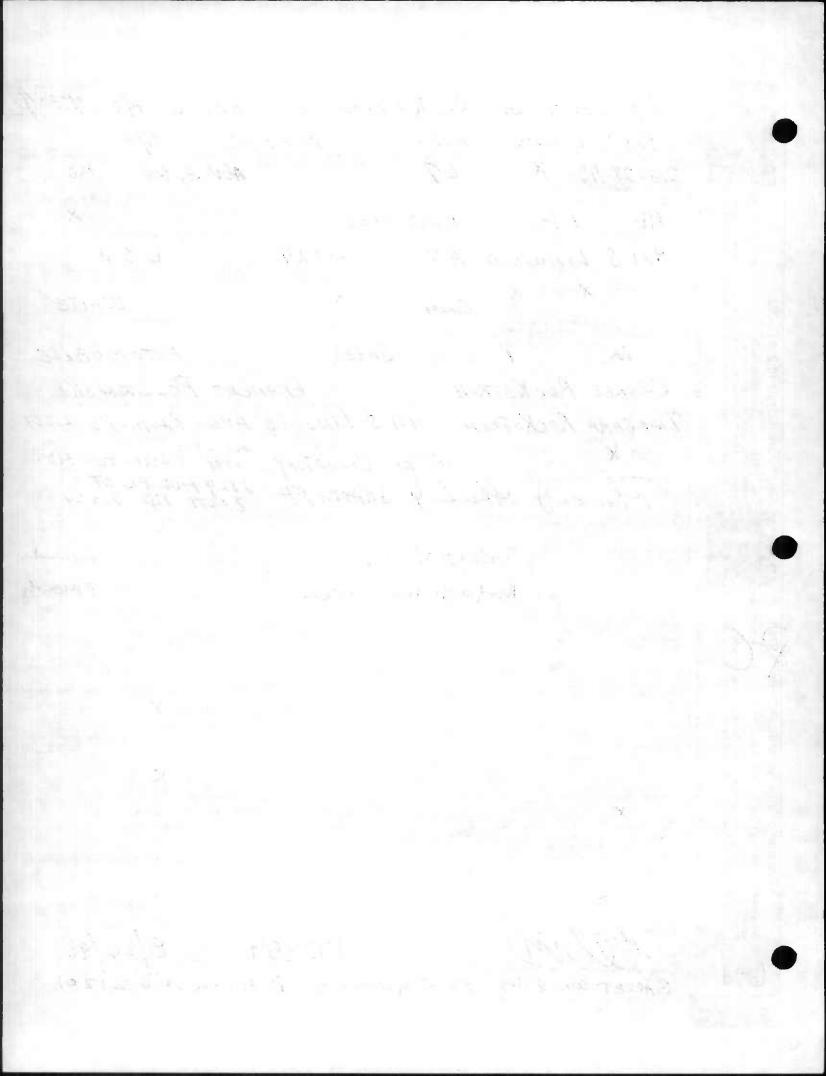
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1 Inpatient 2 ER/Outpetient 3 DOA

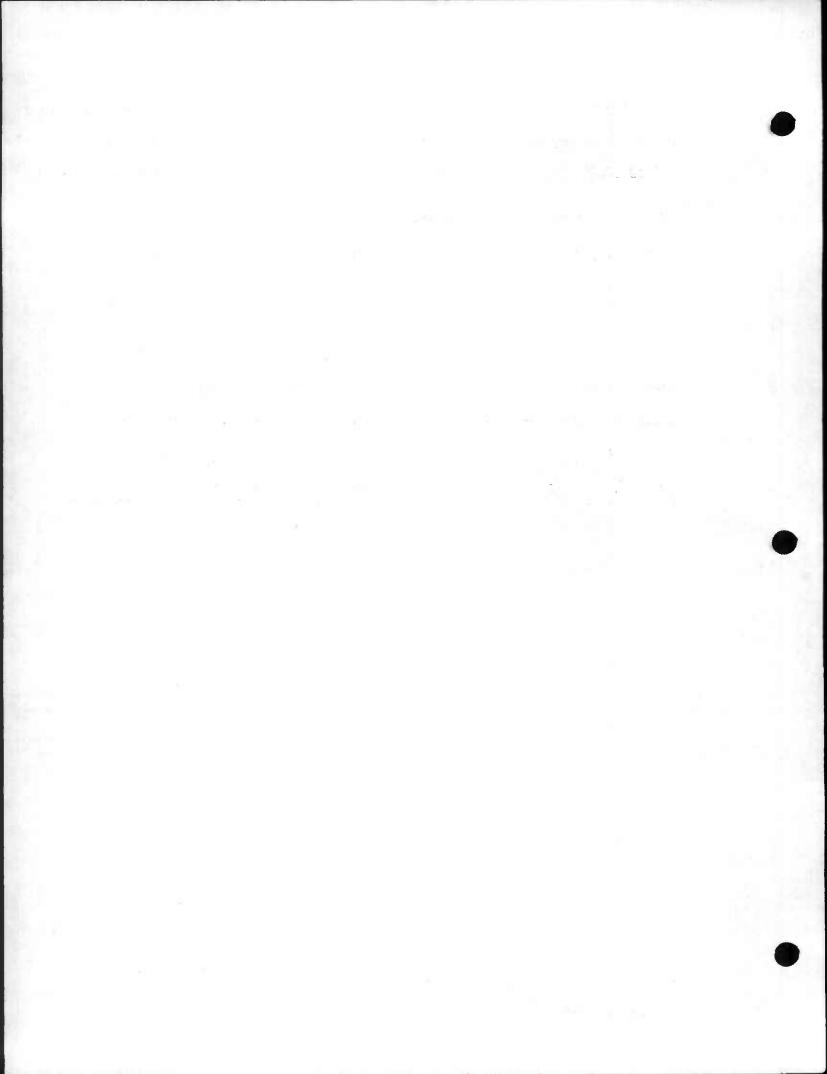


State of Maryland / Department of Health and Mental Hygiene 98 25529

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Physician	1. Decedant's Name (First, Middle,		1	/ _		2. Dete of Dea	ith Dey	Year 3. T	ima of Death
/Medical	FAWRENC			STRE		AUG.	26,199	98	1.30
Examiner	4a Facility Nama (If not institution,				4b. City, Town, o	r Location of Deeth	4c: County	of Death	
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uneral	2/2-28-9172 Usual Rasidance of Dacadant	6. Sex 112 M 2□ F	67	Yrs. Months			3,1930	Country	D ·
show dat	10a. Stata 10b. County	1	10c. City, Tox	wn or Location				10d. In:	side City Limit:
to to	MD. N	14	BAL	TIMOR	E			13	Yas 2□N
from 23e or 25e-feroment of colline for course of colline Funeral Director	10e. Street end Number			10f. Z	ip Coda		10g. Citizan of W	/hat Country?	
23a	921 S. Li	UWOOD	AVE.		21224		U.	5.A.	
au au	11. Maritel Status	12. Was Decedent Armed Forcas	?	13. Was Deci	edant of Hispanic Origin? ecify Cuban, Maxicen, Pu	(Specify Yes or No- arto Ricen, atc.)	14. Race Black	- Amaricen Inc k, Whita, etc.	lian,
by Fu	1 ☐ Nevar Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced	l 1 Yas 2 □ If Yes, Giva Yaar or Dalas:		1□ Yes			Specify:	WHI	TE
	15. Dacedant's	Education	166	a. Dacedant's Us	ual Occupation		16b. Kind of Bu		1 1
nt, the Medical Completed	(Specify only highest Elamantary/Secondary (0-12)	grade completed) Collega (1-4or	5+)	life. DO NOT	ork done during most of w use retired)	rorking			
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arked atic en	GEORGE K	OCKSTRO	H			UCES 1	ELC:	ZNSI	81
Taum.	19a. Informant's Name/Ralationshi	p (Type, Print)	19	b. Mailing Addras	/	Rural Route Numbe			
m 27 ther t	LARBARA N	OCK SIRDI	1 20h Place	of Disposition (N	LINWOOD	AVE.	20c. Location -	City or Town S	
or of	20a. Method of Disposition  1 Durial 2 Cramation 3	3 □Ramoval from State	nom at	ery, crematory or		AUG-27	_		
ortant: Injury 8.	4 Donation 5 Other (Spe		MET	RO C	REMATORY	1998	BALTO		
Importa any Inju	21. Signature of Funeral Service Li	censea .	le l	22. Nama e	and Addrass of Facility  LDA F.H.	28291 BAUTE	4UDSON	UST	14
	23a. Pert1. Entar tha disaasa, or c shock, or haart failura. List o	omplications that cause	d the death. Do	not antar tha mo	ode of dving, such es card			Appr	oximata
sician	shock, or heart failure. List o	nly one cause on each i	lina.					Intan	val Batwaen et and Death
edical	Immediata Causa (Final disease or condition	Del	who !	Lia.				17	· ak
miner	rasulting in death)	aV		e consequence of	n):			-	west,
ner ner		- Most	actat	ic Ca	MCan			Tu	month
al-transit Examiner	Sequantially list conditions,	0. 10.00	Dua to (or es a	consequence of	):				
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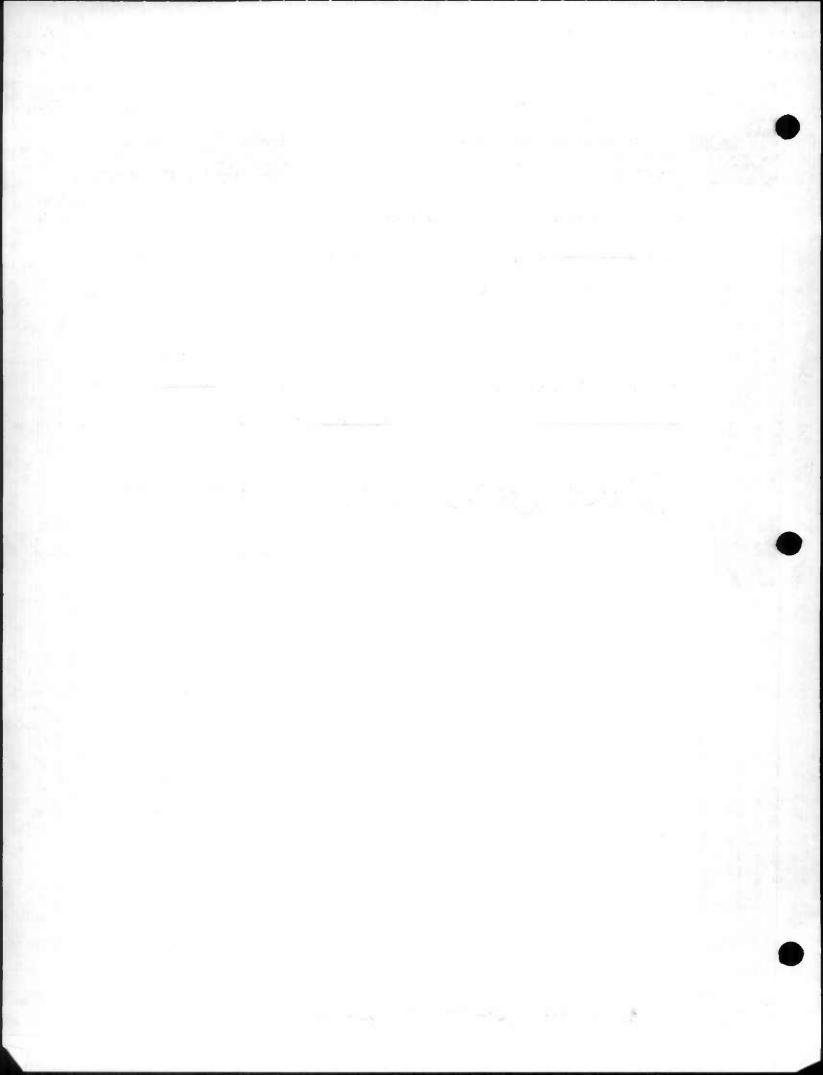


State of Maryland / Department of Health and Mental Hygiene

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24a. Wes an eutopsy performed?  24a. Wes an eutopsy performed?  24b. Were eutopsy finding available prior to completion of cause of deeth?  1	death	Pert II. Other significant conditions co	ntributing to death but not re	esulting in the	underlying cause g	iven in Part I.	23b. Did to	bacco usa con	tributa to the caus	e of deati	
24a. Were autoposy performed?  24b. Were eutoposy finding valiable prior to complete on of deeth?  1	ned by the detach						1 🗆 Y	es 2□ No	3 Probably 4	□ Unkno	
25. Wes case referred to medical exeminer?	ew requires ts been sig 2 should b pleted t								available prio completion or	or to	
25. Wes case referred to medical exeminer?	The late he						1 \ Ye	s X No	1 □ Yes 2	□ <b>X</b> ₀	
1   Yes 2   Show   28d. Describe how injury occurred   28d.	antifica ctor.					26. Place of De	ath (Check only on	θ)			
Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of Person who completed cause of death (Item 23a) (Type, Print)   Second Process of P	S S D		Hospitel: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA	her: 4 Nursing H	lome 5 ☐ Reside	nca 6 □Othe	or (Specify)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FRANCIS KHOO, M. D., 7620 YORK ROAD TOWSON, MARYLAND 21204	ath. r: After ti he funera	Neturel 5 □ Pending	28e. Date of Injury (Month, Dey Year)				28d. Describe ho	ow injury occurre	ed		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FRANCIS KHOO, M. D., 762Ø YORK ROAD TOWSON, MARYLAND 212Ø4	al or Attender de l'Directo d in by th	3 ☐ Suicide 6 ☐ Could not be	288. Pieca of injury - At	28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)			ce 28f. Location (Street end Numi City or Town, Stete)		er or Rural Route Nu	mber,	
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M. D., 7620 YORK ROAD TOWSON, MARYLAND 21204	• Hospit 124 hours • Funera letely fille	(Check only 2 Medical Exam	ner: On the basis of examin	nowledge, dea nation and/or is	th occurred at the t nvestigation, in my	ime, date end place opinion, death occu	, end due to the ca pred at the time, de	ause(s) and ma ate and place, a	nner es stated. and due to the cause	∍(s)	
30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M. D., 7620 YORK ROAD TOWSON, MARYLAND 21204	Methin Nomp	29b. Signeture and title of certifier		0 -	29c. Licen	se number	2			)	
FRANCIS KHOO, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204	- > - 0	1 7	made	Mus	D 308	263		8-25	-98		
						JSON MA	DVI ONT	01007			
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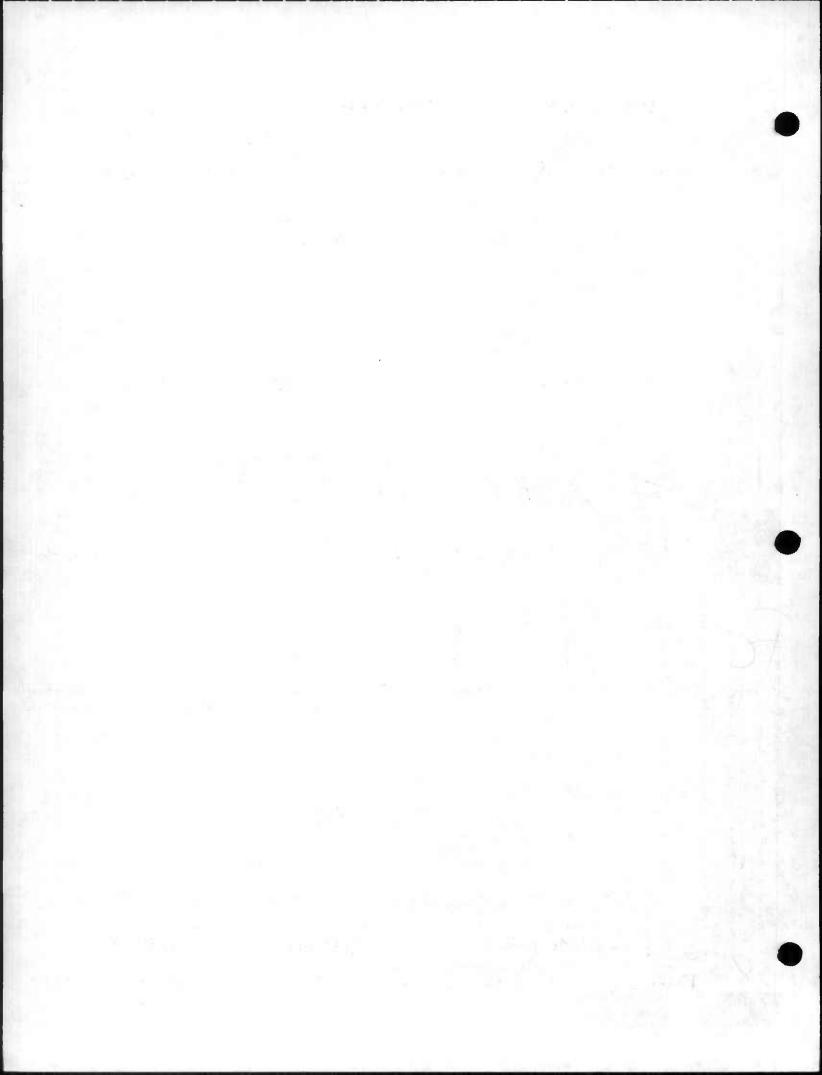
hysician		. Decedent's Neme (First, Middle	Last)			rtificate of		2. Dete of Dee	Reg. No.		3. Time of Deeth
/Medical		Josephine	M. Smit	h				Month	29 /	Year 1998	2:27pm
xaminer	4	e. Fecility Neme (If not institution,	give street end n	um <i>ber)</i>	H.		4b. City, Town, or I	Location of Deeth	4c. County	y of Deeth	
	L	Stella Maris H		-			Baltim		N	19	
neral ector		215-28-8625	6. Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs.	() Yrs.	If Under 1 Year Months Deys	Hours Min.		, Yeer) , 1928	9. Birthpl Coun Mary 1	leca (Stete or Foreign try) Land
ž	1	Usuel Residence of Decedent  Oa. State  10b. County		10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits
to to	N	Maryland Balti	more		ltimor						1 ☐ Yes 2 No
ms 23a or 28a-f show count be notified at neral Director		Oe. Street end Numbewood				10f. Zip Code			10g. Citizen of	Whet Coun	itry?
		8715 Belairwood	Road, #	A4		2123	6		U.S	.A.	
tem 27 is marked other than 'natural', or items 23s or 28s-f show other traumatic event, the Medical Experient must be notified at To Be Completed by Funeral Director	١.	Marital Status     Never Married 2 Marrie     Widowed 4 □ Divorcad	12. Was Der Armed F 1 ☐ Yes If Yes, G Yeer or I	cedent Ever in Lorces?  2X No ive Detes:		Was Decedent of I If Yes, specify Cub I□ Yes ②□ No	Hispenic Orlgin? (S een, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Bla Specif	ce - Americack, White, of	
n, the Medical I	-	15. Decedent's (Specify only highest Elementery/Secondary (0-12)	) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire memaker	pation during most of wor d)	rking	16b. Kind of Business/Industry  OWN home			
evant, Be Co	1	7. Fether's Neme (First, Middle, L	_		110	memaker ,	18. Mother's Nan	ne (First, Middle,			
TOB		William Frank H	lenderson	1			Velma B1	anch <del>Dul</del>	<del>laney</del> S	haffe	r
		19a, Informant's Name/Relationsh JOHN THOMAS SMITH	R. PHUSBAI	ND	19b. Maili	BLATRWOO	and Number or Ru	ıral Route Numbe	r, City or Town	Code)	
her		John Smith/husb	and-				ed Road,				21236
any injury or other tr once.		0e. Method of Disposition  1 □ Burlal 2 □ Cremation  4 ☒ Donation 5 □ Other (Sp.	ecify)		Placa of Dispo cemetery, crei	sition (Neme of netory or other ple	oce)	Dete	20c. Location	- City or To	wn, State
any in	1	Ronald	S. Wade	pirecto	r S	Name and Addre tate Ana altimore	tomy Boar		W. Balt	imore	Street
ician dical niner	100	23a. flarf1. Enter the diseese, or c stock, or heart feilure. List o mmediete Ceuse (Finel diseese or condition esulting in deeth)	nly one ceuse on	eech line.		RECTA	c CAn		1001,		Approximate Intervel Between Onset end Deeth
g physician and es the buriel-trensit	L		b. ———								
dical	1	Sequentielly list conditions, f eny, leeding to immediate cause. Enter Underlying Jeuse (Disease or Injury het initieted events esulting in deeth) Lest	c		or es e consec or es e consec						
the bu	1	esulting in deeth) Lest	d.	Due to (c	or es e conseq	uenca of):	von in Port I	22b Did t	ohanna was na		the name of death?
leteched for use es the bur Physician/Medical	1	net initieted events	cds contributing to d	Due to (c	or es e conseq	uenca of):	ven in Pert I.		obacco uea co ∕es 3⊠No		o the cause of death? pably 4 □ Unknown
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annote has been agneed by the enanding physical price of the page 2 should be deteched for use as the burner of the page 2 should be deteched for use as the burner of the page 2 should be detected by Physician/Medical	F	esulting in deeth) Lest  ert II. Other significant condition  5. Wes case referred to medical exeminer?	Hospital	Due to (c	or es e consequence of the conse	uenca of):  nderlying cause gi	26. Plece of Dec	1 U Y  24e. Wes of performance of the performance o	en eutopsymed?  Yes 25No	3 Prot	pebly 4 Unknown  are eutopsy findings eileble prior to mpletion of cause deeth?  Yes 2 No
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To Be Completed by Physician/Medical	2	sesulting in deeth) Lest  ert II. Other elgnificant condition  5. Wes case referred to medical exeminer?  1	Hospital:  28e. Dete (Moi tion 28e. Plec build  Phyelclan: To the taminer: On the b	Due to (of death but not resident but no	DEF/Outpetier 28b. Time of Injury ome, farm, str	uenca of):  Inderlying cause given the distribution of the distrib	26. Plece of December: 4 □ Nursing Hay et fk? Yes 2 □ No me, dete end place opinion, death occurse number	24e. Wes a perfor  1  Yes th (Check only or	en eutopsymed?  Yes 25 No ne) 57 57 67  Jenca 6 50 10  Jenca 6 10  Jenca 6 10  Jenca 6 10  Jenca 6 10  Jenca 10  Jen	3 Prob  24b. We expended to the control of the cont	pably 4 Unknown  are eutopsy findings sileble prior to mpletion of cause deeth?  Yes 2 No  No. 18 No
uneral director, page 2 should be deteched for use as the but on: To Be Completed by Physician/Medical	2 2 2	sesulting in deeth) Lest  ert II. Other significant condition  ert II. Other significant condition  5. Wes case referred to medical exeminer?  1	Hospital: 1	Due to (of death but not resident but no	DER/Outpetier  28b. Time or Injury  ome, farm, str	uenca of):  Inderlying cause given the distribution of the distrib	26. Plece of Dee ner: 4□ Nursing H ny et nk? IYes 2□ No me, dete end place	24e. Wes a perfor  1  Yes th (Check only or	en eutopsymed?  Yes 25 No ne) 57 57 67  Jenca 6 50 10  Jenca 6 10  Jenca 6 10  Jenca 6 10  Jenca 6 10  Jenca 10  Jen	3 Prob  24b. We expended to the control of the cont	pably 4 Unknown  are eutopsy findings sileble prior to mpletion of cause deeth?  Yes 2 No  Note of the cause deeth?



State of Maryland / Department of Health and Mental Hygiene

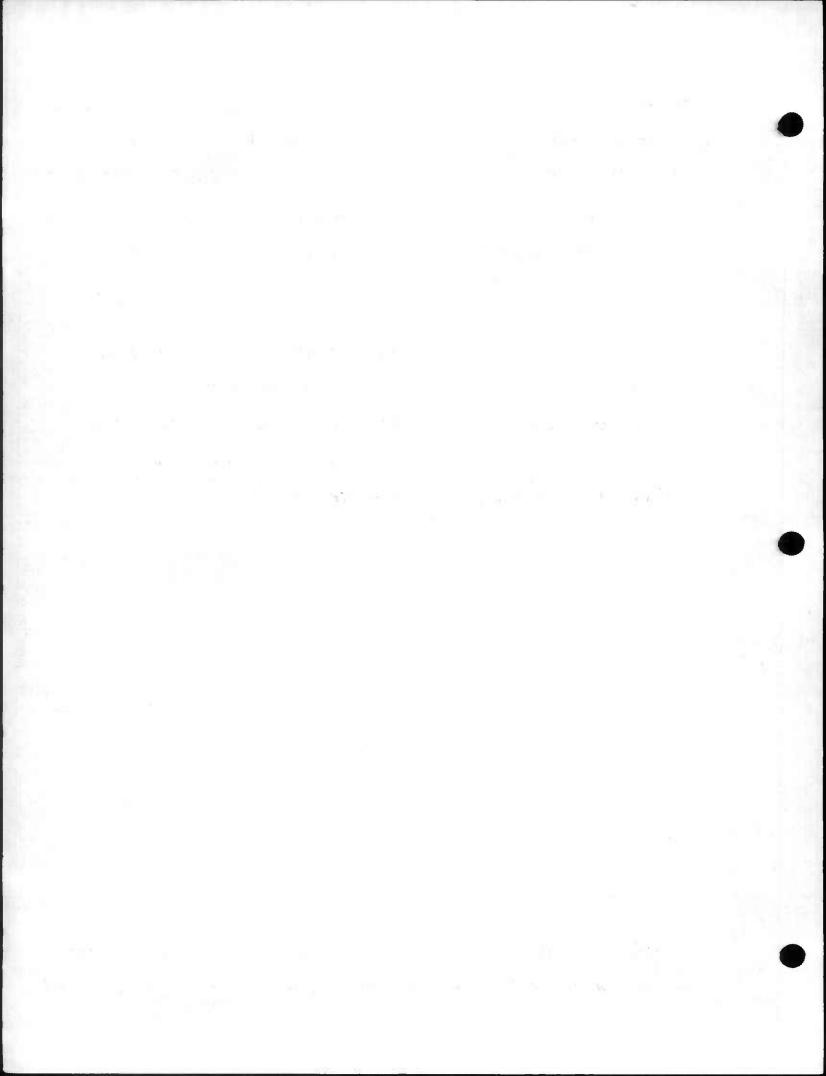
100	Decedent's Name (First, Middle,	Last)		Oeri	invale (	of Death	2. Dete of D	Heg. No.		26533
ysician Medicai	WILLIA	SCH	ELL		Month					
kaminer	4e. Fecility Neme (If not institution, 5912 MOOREHEAD		er)				or Location of De	eth 4c. Cour	nty of Deeth	
			Ane /in vrs	last birthday)	If Under 1 Y	CATONS ear If Under 24			BALTIN	
neral octor	218–26–9134	10 M 2□ F	68	_			Min. 8. Date of E (Month, I 6/13/	Dey, <i>Year)</i> 1930		lece (Stete or Forei try) 'LAND
	Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Loca	ation				1	0d. Inside City Lim
tor	MD BAI	TIMORE				CATON	SVILLE			1 □ Yes 2 <b>/□</b> /
Examiner must be notified at by Funeral Director	10e. Street end Number 5912 MOOREHEAL	ROAD			10f. Zip Co	de 21228		10g. Citizen o	U.S.	,
by Funeral Director	11. Marital Status  1 Never Married 20 Marrie  3 Widowed 4 Divorced	1 ☐ Never Married			as Decedent Yes, specify	of Hispenic Origin' Cuben, Mexicen, P No Specify:	? (Specify Yes or Nuerto Rican, etc.)	14. R B Spec	ece - Americ leck, White,	etc.
To Be Completed to	15. Decedent's		s: 	16e. Decede	ent's Usuei O	cupetion		16b. Kind of	Business/Inc	
Completed	(Specify only highest Elementery/Secondary (0-12)	grede completed)  College (1-40	r 5+)	(Give kind of work done during most of work life. DO NOT use retired)			working	orking		
S	17. Fether's Neme (First, Middle, La	4		MECHAN]	ICAL E	1	Name (First, Midd			L ELEMEN
To Be	MARTIN VAN SCH						VE CORRI			
-	19e. Informent's Name/Reletionship	p (Type, Print)		19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zi					vn, Stete, Zip	Code)
	MARIE C. SCHELL  20e. Method of Disposition	(WIFE)	20h	The State of the S					MD 212	
	Matrice of Disposition  1 □ Burial 2 □ Cremation 3  4 □ Donetion 5 □ Other (Spe		e	cemetery, creme	etory or other	plece)	Date		n - City or To	
á	21. Signature of Funeral Service M		LOI	RRAINE I		IMETERY dress of Fecility W	8/31/98			IARYLAND
once	D Ha	titt				ONDSON AV		SVILLE,		
Medical Examiner	Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest	b	Due to (	or es e conseque or es e conseque or es e conseque	ence of):				1	
Physician/Me	Pert II. Other significent conditions	e contributing to death	but not res	ulting in the und	ledvina couc	niven in Pert I	22h Di	d tobacco uco	ontribute to	the cause of deat
by Phys	Town algimoni conduction	contributing to death	Dut not res	atting in the und	enying ceuse	given in Pen I.	1)	Yes 2 No		eably 4 Unknow
Completed !								es en eutopsy formed?	eve	ore eutopsy findings ellable prior to appletion of ceuse deeth?
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o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospitel:	tient 2	ER/Outpetient	3□ DOA	Other:	Deeth <i>(Check only</i>		ther /Snecifi	()
on: T	27. Manner of Deeth  1 Naturei 5 ☐ Pending	28e. Dete of In (Month, D		28b. Time of Injury		njury et Work?		dome 5 Residence 6 Other (3		,
ficati	2 Accident investigat 3 Suicide 6 Could not	be Ope Blace of It			M 1 Yes 2 No			294 Location (Chapter of March 1997)		I Route Number
Certification:	4 ☐ Homicide determine	nome, farm, street, fectory, office  28f. Location (Street end Number or Rural Route Numb City or Town, Stete)								
	Check only 2 Medical Ex	Phyeician: To the bes aminer: On the basis end menner s	of examine	wledge, deeth o tion end/or Inve	occurred et the stigetion, in n	e time, dete end pla ny opinion, deeth o	ece, end due to the courred et the time	e ceuse(s) end r e, dete end piece	menner es sto e, end due to	eted. the ceuse(s)
	one)				29c Llo	ense number		29d. Date sign	ned (Month I	Day Year!
Medical	29b. Signeture end title of certifier				200. 210			Lou. Date sign	iod (inoritri, t	Juj, 1001/

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State of Maryland / Department of Health and Mental Hygiene

Physici		Decedent's Neme (First, Middle, L.				inouto	of Death	2. Date of Dec			me of Death		
/Medio		DR. EARL LESI	LIE SA	ASSER,	SR.			Month AUGUST	25, 199	Year 98 8•	30AM		
Examiner		4a. Facility Neme (If not institution, gr 10433 WATERFO		3			4b. City, Town, or COLUM	Location of Death	4c. County		20711		
Funeral Director				e (In yrs. las	st birthday) 5 Yrs.	If Under 1 Months		s. 8. Data of Birt	h, Year) /1903	9. Birthplace (S Country) NORTH	caroli		
show	2	10a. Stete 10b. County		10c. City,	Town or Lo						ide City Limits		
ott ac	Director	MD HOWAI  10e. Street end Number	RD				COLUMBIA		10 07 11		Yas 200		
Hygiene. ther than "natural", or itema 23a or 28a-f show ent, the Madical Examiner must be notified at		10433 WATERFOW	L TERRACE			10f. Zip C	21044		10g. Citizen of W	.S.A.			
"natural", or itema 23a or 28a-f show ad cal Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Navar Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces?  1  Yes 2  ht Yes, Give Yaar or Datas:			Was Deceder f Yas, specif 1 ☐ Yes 2	nt of Hispenic Origin? ( y Cuban, Mexican, Pue ☑ No Specify:	Specify Yes or No- rto Rican, atc.)		e - American Indi k, Whita, atc.	en,		
th and Mental Hygiene. 7 Is marked other than "natur traumatic event, the Medical	Completed	(Specify only highest g	15. Decedent'e Education (Specify only highest grada completed)  Elemantery/Secondery (0-12)  College (1-4or 5+) 5+			dent's Usual kind of work DO NOT use	done during most of wo	orking	16b. Kind of Bu	siness/Industry			
the M	omb	Elemantery/Secondery (0-12)					ENGLISH		HIGHER		TION		
Health and Mental Hygiene. am 27 is marked other than other traumatic event, the M	Be	17. Fether's Neme (First, Middla, Las GEORGE SASSER	t)					ma (First, Middle,		Θ)			
nd Mer marks matic	2	19e. Informent's Name/Reletionship	(Type Print)		19b Mailir	na Address (	Street end Number or F	Y (WHITE	,	State Zin Code)			
alth ar 27 Is or trau		EARL SASSER, JR					JRE GATE LA		MBIA, MI				
		20e. Method of Disposition  **DXBuriel 2		20b. Ple	ce of Dispo	sition (Neme netory or oth	of ar place)	Dete 8/31/98	20c. Location -	City or Town, Ste			
Department of Important: If it any injury or once.		21. Signeture of Funaral Service Lice	nsee				Address of Facility W	TTZKE FU	NERAL HO LUMBIA,				
ysician Medical aminer	ner	Immediate Cause (Final diseasa or condition resulting in deeth)		Due to (or e	0/ // 11/2/2		e Diovas Cur	AL DISE	ASE		and Death		
mescian end the borial-transit	edical Examiner	Sequentielly list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or Injury that Initiated events resulting in daath) Last	C	Due to (or a									
efferdings for use as	0000		d										
the ett hed fo	Physician/N	Pert II. Other significant conditions	contributing to death bu	ut not resulti	ing in the ur	nderlying cau	ise given in Part I.	23b. Dfd t	obacco use con	tribute to the ca	use of deat		
80	by Ph	DEMENTIA						10	Yes 2□No	3 Probably	4 Unkno		
0.0	Completed I							24e. Wes perio	en eutopsy med?	24b. Were auto eveilable p completio of deeth?	opsy findings prior to n of cause		
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ate has pege 2	To Be	25. Wes case referred to medical exeminer?  1 Yes 2 No	Hospital:	nt 2 🗆 E	2/Outpetien	t 3 DOA	Othor	eath (Check only o		or (Canaiba)			
ate has pege 2				27. Menner of Deeth 1 ☑Naturel 5 ☐ Pending	28a. Dete of fnjur (Month, Day	y 2	8b. Time of Injury		c. Injury et Work? 1 Yas 2 No		now injury occurre		
is certificate has director, pege 2		2 Accident invastigation		oma, farm, street, fectory, office			28f. Location (S City or Tox	Street end Numbe vn, Stete)	er or Rural Routa	Number,			
is certificate has director, pege 2	Certification:	3 Suicida 6 Could not l determined	building, etc										
is certificate has director, pege 2	Certification:	3 Suicida 4 Homlcide 6 Could not I determined	building, efc	of my knowle	edge, death n end/or inv	occurred et restigetion, in	the time, date end plec n my opinion, deeth occ	a, and due to the ourred et the time,	ceuse(s) and mer date and piece, e	nner es stated. end due to the ca	use(s)		
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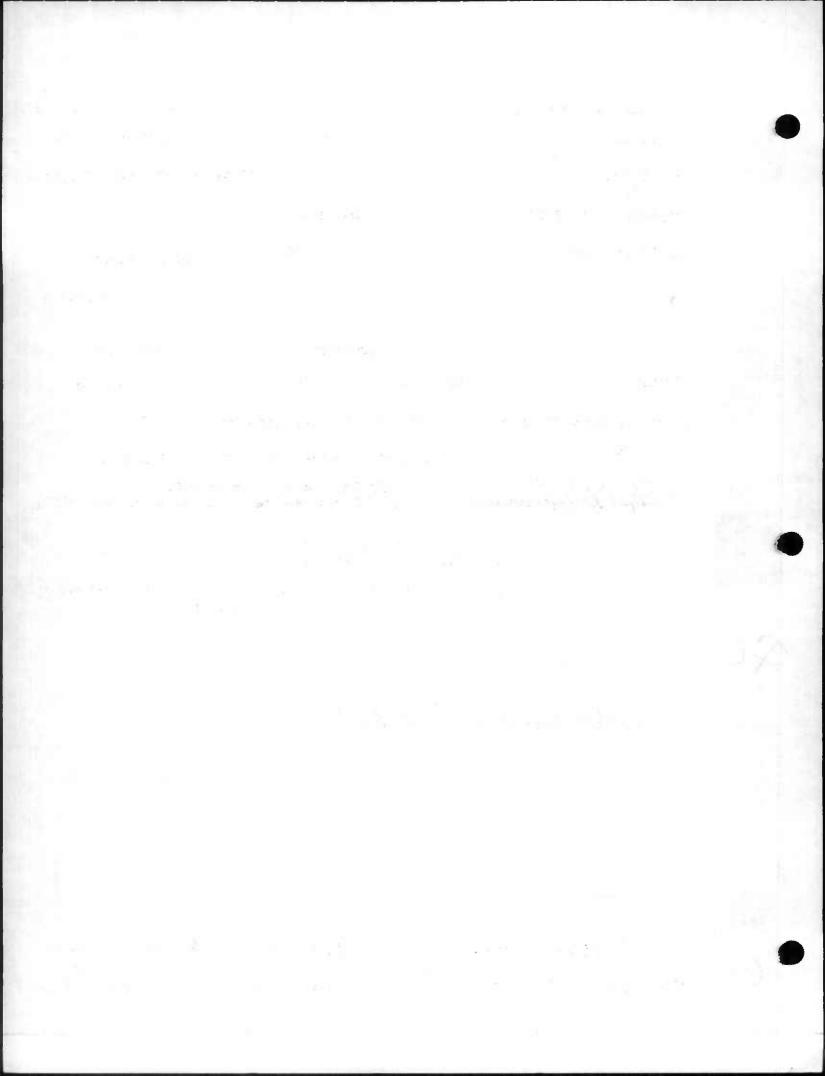
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Baltimore, Maryland 21215-0020	72 ho	15. Decedent's (Specify only highest g	rade completed)		ecedent's Usuel Oc Give kind of work do ife. DO NOT use ret	cupetion ne during mos tired)	t of working	16b. Kind of E		
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ore	of He	20e. Method of Disposition 1 ☐ Burial 2 【XCremetion 3	Removal from State	20b. Place of E cemetery,	Disposition (Name of cremetory or other p	place)	Dete	20c. Location	- City or To	wn, State
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Ball	permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is merked other than *, any Injury or other traumetic event, the Mex. DRGs.	21. Signeture of Funerel Service Lice	ensee	1	22. Name and Ad March I		lest			
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8/28/98 7:10 AM Dorothy B. Stevenson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Forest Hill Mariner Health of Forest Hill Harford County if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral**  Birthplace (Stete or Foreign Country) 1□ M 2XF Sept. 18,1921 Yrs. 76 Director 233 28 5352 West Virginia Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at Maryland Harford Edgewood 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 Van Bibber 21040 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decadent Ever in U,S. Armed Forces? permit. Peges 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Exercises once. 1 ☐ Yes 2 No 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: White by 3 Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Bradshaw Ora Heddrick 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Stevenson / Son 1502 Holman Dr., Edgewood, MD Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX cremation 3 ☐ Removal from State Green Mount Crematory 8/29/98 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funeral 8 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. Loblumann 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical immediate Cause (Final several diseese or condition resulting in death) Examiner Physician/Medical Examiner refused tube Feedings Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting In deeth) Last pue Due to (or es a consequence of) P.O. Box The law requires that the death Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? erebrovascular Acci 1 Yee 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital tal or Attanding Physician: The star death.

al Director: After this certificate led in by the funeral director, pa 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 | Inpatient 2 | ER/Outpetient 3 | DOA 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di 1 Certifying Phyaician: To the best of my knowledge, death occurred et the time, date and placa, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of cartifigure 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 8 Law Street, Aberdeen, Maryland 32 Registrar's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene

		Certi	ficate of Death	Reg. N		000/
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	Funeral Director	5. Social Security, Number 6. Sex 7. Age (In yrs. Test birthday) 185 30 3886 71 Yrs.	If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Dete of Birth (Month, Dey, Yee		ece (State or Foreign try) sylvania
	f show	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Loca   Maryland   n/a	Baltimore		16	Od. Inside City Limits  17 Yes 2 No
	rs efter death with the Merylan , or items 23a or 28a-f show carriest must be notified at	100. Street end Number 1101 N. Calvert St	10f. Zip Code 21202		Citizen of Whet Coun	
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Divis	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director, After thi completely filled in by the funeral Madical Cartification.	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place ot Injury - At home, term, stree building, etc. (Specify)	t, fectory, office	28t. Location (Street City or Town, Sta	en <i>d Number or Rura</i> ate)	l Route Number,
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	P	30. Name end address of person who completed cause offeeth (Item 23e) (Type, Pr Louis E. Grenzer 3015t.	Pul Place	±815 13	. Ito md	21202
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State of Maryland / Department of Health and Mental Hygiene

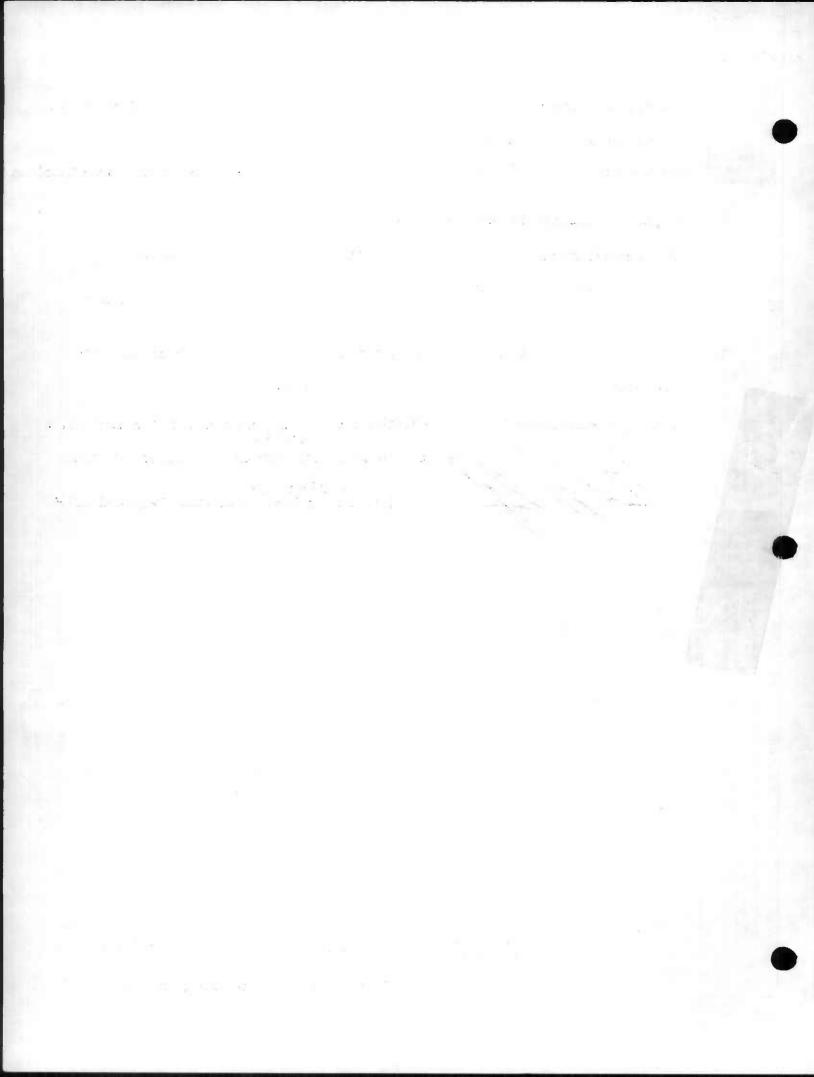
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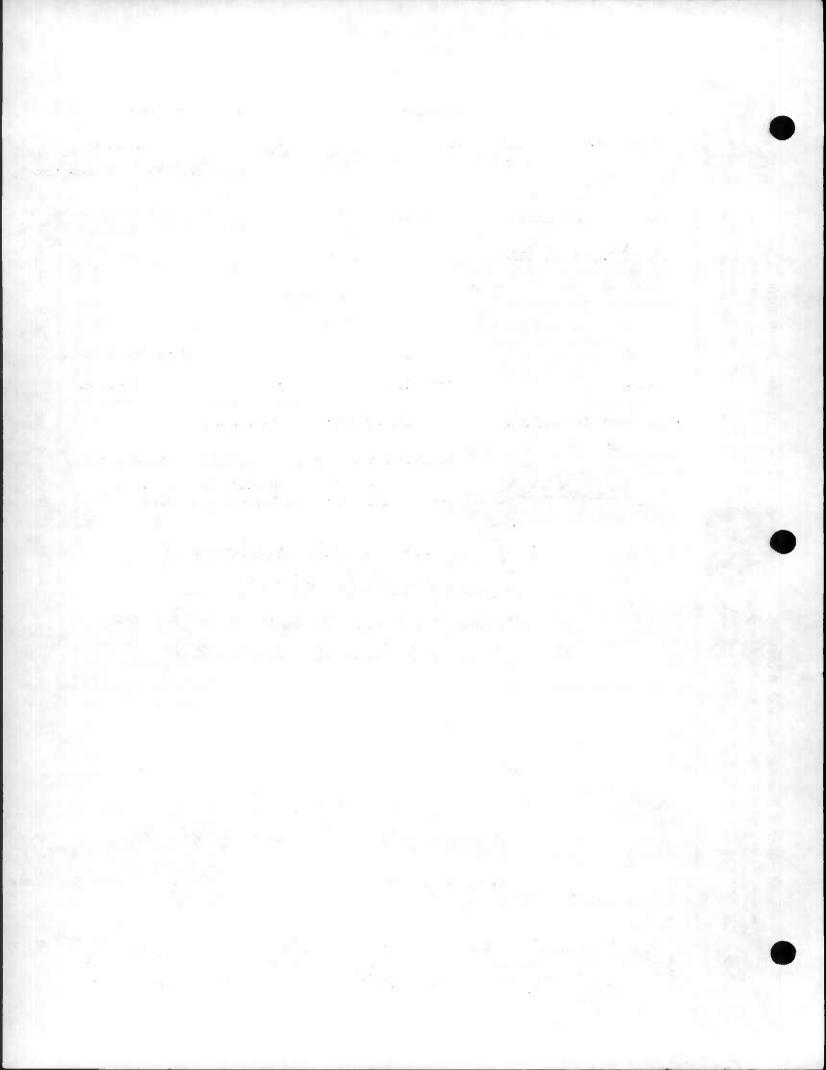
11EMS: #23	PART I, II, 27 PER MEO  1. Decedent's Nema (First, Middle, Las		. 001	tificate of	Doda	2. Dete of Dea		3. Time of Deeth
Physician	Angela D. Severe	2				Month		Yeer 998 2:45 P.M.
/Medical Examiner	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or L	-	4c. County o	
	Northwest Hospita						Baltimo	
Funeral Director	378-84-6892	7. Age (In yrs. 37	last birthday) Yrs.	If Undar 1 Yaer Months Deys	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Dey Aug. 2]	(, Yeer)	9. Birthplace (State or Foraign Country) North Carolina
rms 23a or 28a-f show rmst be notfled at neral Director	Usuel Rasidence of Decedent  10e. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
items 23s or 28s-f show ther must be notified at -unersi Director	Maryland Baltimon	re County Rei	sterst	own				1 ☐ Yas 2 ØNo
rec par	10e. Street end Number			10f. Zip Code		1	I0g. Citizen of WI	het Country?
al C	69 Mainbrook Court	:		21136			U.S.A.	
by	11. Merital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Ever in U Armed Forces? 1 ☐ Yas 2X No If Yes, Give Yaer or Detes:		Ves Decedent of H Yas, specify Cub Yes 2\( \) No	dispenic Origin? (Spen, Mexican, Puerto Specify:	pecify Yes or No- p Rican, atc.)	Bleck	- Amancan Indian, , White, etc. White
Completed	15. Decedent's Ed (Specify only highest gre Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)			pation during most of work d)		16b. Kind of Bus	
S	17. Fether's Neme (First, Middle, Last)	2 Years	Spec	ialist	18. Mothar's Nam			omputers
Be	Unknown				Unknown			
To	19a. Informent's Name/Reletionship (1	vpe, Print)	19b. Meilin	g Address (Street	end Number or Rus		r, City or Town. S	Stete, Zip Code)
יו ניפו	Robin L. Severe/Hu							yland 21136
or other traumatic svent, the Madical To Be Completed	20e. Method of Disposition	20b. I			ce) 8/28/98			City or Town, State
iry of	1 ☐ Burial 2 🖾 Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Hemover from State	timore	/Washing	ton Crema	tory	Laurel,	Maryland
any injury or other traumatic svent, the Manage.  To Be Compi	21, Signature of Fundal Septice Licen	see //	J		iller, In			23 21206
	23a. Part1. Enter the disease, or some shock, or heart failure. List only	lication that caused the dea	th. Do not ante	er the mode of dying	ng, such es cardiac	or raspiratory er	re, Mary.	land 21206 Approximata interval Between
ician	SHOCK, OF Heart failure. List Only	one description.						Onset end Deeth
dical	Immediate Ceuse (Final disaese or condition	PNEUMONI	Α					
niner	resulting in deeth)	Due to (	or es e conseq	uence of):				
nine		b						
edical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Undertying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	C	or es a conseq or es e conseq					1
		d						
datached for use as	Pert II. Other significant conditions of	ntributing to death but not res	sulting in the ur	nderlying cause giv	ven in Pert I.	23b. Did to	obacco uee cont	tribute to the cause of death?
be datact by Phy	STATUS POST KIDNEY	TRANSPLANT				101	/es 2□No	3 Probably 4 Unknown
2 should pieted	ARTHRITIS					24e. Wes a perfor		24b. Were eutopsy findings avallabla prior to completion of cause of deeth?
director, page To Be Com	HYPERTENSION					104	65 2 □ No	Mes 2 No
Be C	25. Wes case referred to medical examinar?				26. Plece of Dee	th (Check only or	ne)	
-	1 Z Yes 2 □ No		ER/Outpatien	I SLI DUA			lence 6 Otha	
tion:	27. Manner of Death 1 🖾 Naturel 5 🗆 Pending 2 🗆 Accident invastigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of injury	Wo	ry et rk? ] Yas 2 ☐ No	28d. Describe h	ow injury occurre	od
lad in by the tunera Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stro	eet, factory, office		28f. Location (S City or Tow		r or Rurel Route Number,
completely filled in by the Medical Certifical	29a. Certifier 1 Certifying Phyone) 2 Medical Example 1	rsicien: To the best of my known iner: On the besis of examine and manner stated.	owledge, deeth etion end/or inv	occurred et the tivestigation, in my o	me, date end plece, opinion, deeth occur	, end due to the or rred et the time, o	cause(s) end men date end piece, e	nner es steted. nd due to the cause(s)
completely filled in by the	29b. Signature and title of certifiar	1 0		29c. Licens			and the same	(Month, Dey, Year)
	Menni	& Chutas		O.C.1	M.E.	A	august 20	5, 1998
	30. Neme end eddress of person who	ompleted cause of deeth (Ite	m 23e) (Type,	Print)				
	Dennis J. Chu			11 Penn S	Street, B	altimore	e, Maryla	and 21201
State Registrar	31. Dete filed (Month, Dey, Year)  NIC 9 1 190	32. Registrer's Sign		Spark	2			



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State	i wai yiai		rtificate o	f Death		Reg. No.	26540
			1. Decedent's Name (	First, Middle, La	st)				S. Paul Bo	2. Dete of Dec		3. Time of Death
	Physicia		ANN			mp Ti	מוצנואווכ			Month	Dey Ye	12:35 PM
	/Medic Examin		4e Fecility Neme (If n	ot institution, giv	e street end nun		NKHAUS		4b. City, Town, or L	August ocation of Deeth	24 1998 4c. County of D	
A	Examin	•	Dulaney To	owson M	reina C	ontor			Mourgan		Dalti	
1	Funeral		5. Social Security Nun			7. Age (In yrs.	lest birthdey	If Under 1 Yea		8. Date of Birt (Month, Da	Balti	Birthplece (Stete or Foreign Country)
L	Director		069-28-58 Usuel Residence of D	15	□M 2점F	89	Yrs.	Months Dey	s Hours Min.	June 1		New York
	hend w			0b. County		10c. Ci	ty, Town or L	ocation				10d. Inside City Limits
	Mary	ō	Md.	Balti	more		Towso	n				1 ☐ Yes 2 🛣 No
	the 28s	Director	10e. Street end Numb				101100	10f. Zip Code			10g. Citizen of Whet	Country?
	With With		205 5 7	oppo Dd	#1104			2120				
	leath The 23	era	205 E. Jo	орра ка.		dent Ever in U	.S. 13.	Was Decedent of		pecify Yes or No	USA 14. Race - A	merican Indien,
21215-0020	72 hours after death with the Marylend "netural", or items 23s or 28s-f show toles! Evanither must be notfled	by Funeral	1 ☐ Never Married 3 🖫 Widowed 4		Armed For 1 Yes If Yes, Giv Year or Da	rces? 2 XNo e		If Yes, specify Cu 1 ☐ Yes 2 ☑ N	f Hispenic Origin? (Spuben, Mexicen, Puerto o Specify:	Rican, etc.)	Specity:	/hite, etc. White
0-10	2 ho	ह	121	5. Decedent's Ed	lucetion		16e. Dece	dent's Usuel Occ	upetion		16b. Kind of Busine	ess/Industry
218	S - 3	Completed	(Specify Elementary/Second	only highest gre	College (1	-4or 5+)	life.	DO NOT use reti	ne during most of work ired)	king		
21	filed withir Hygiene. ther then	E	12	lary (0-12)	Oollege (1	401 04)	Wrap	per			Departmen	t Store
P	should be filed and Mental Hygie marked other imatic event, in	Be	17. Fether's Name (Fi	irst, Middle, Last)					18. Mother's Nem	e (First, Middle,	Maiden Sumeme)	
Maryland	Mentai Mentai arked o	0	Gustav			Sc	hindle	r	Mary		Kr	asner
ary	2 should and Men is marke aumatic	-	19a. Informent's Nam	e/Relationship (	Type, Print)		19b. Mail	ing Address (Stre	et and Number or Ru	rel Route Numbe	er, City or Town, Ste	te, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any Injury or other traumetic once.		Mrs. Nancy 20a. Method of Dispos 1 Durial 2 4 Donetion 5 21. Signature of Fune	sition Cremation 3 ☐ ☐ Other (Specif	Removel from 5	State	Place of Disponentery, creations of the Disponentery of the Dispon	osition (Name of matory or other p Service 2. Name end Add	Corp.	Dete 8/28/98	20c. Location - City Towson,	or Town, Stete
			23a. Part1. Enter the shock, or heart f	E) De	Man A	0		1050 Yor	k Rd. Tows	son. Md.	21204	
Box 68760,	Sharp continued by secured attending physician attending physician attending physician attending the physician attending to the physician att	in/Medical Examiner	Immediate Ceuse (Fir disease or condition resulting in deeth)  Sequentially list cond if eny, leading to imm ceuse. Enter Underly Ceuse (Disease or injithat initiated events resulting in deeth) Les	itions, ediete ring iury	b. 87 >	Due to (c	or es e conse	quence of):	mbol Fract whole le Den	cular	l) seds.	Onset end Death
P.O.	es thet the death cer igned by the attendir be dateched for use	y Physician/M	Part II. Other elgnifica	ant conditione c	ontributing to de	ath but not res	ulting in the	underlying ceuse	given in Part I.			oute to the cause of death?  Probably 4 Unknown
Records,	s law requires thet the has been signed by th je 2 should be dateche	Completed by								24a. Wes	en eutopsy 24	4b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?
H	The tet h	5								10	Yes 2 No	1 ☐ Yes 2 ☐ No
Vital	certificate	Be	25. Wes cese referred	to medicel					26. Piece of Dea	th (Check only o	one)	
f \	2 00	9	exeminer?		Hospital:	npatient 2	ER/Outpetie	ent 3 DOA	Other: 4 Nursing H	ome 5 Resi	dence 6 Other (	Specify)
Division of	tal or Attending rs eftar death. al Director: After ed in by the fune		2 DAccident 3 Suicide 4 Homloide  29a. Certifier 1[	Medical Exam	28e. Plece buildir ysiclan: To the	of Injury - At hing, etc. (Special best of my knows of examina	y) 20 To wiedge, dea	th occurred et the nvestigation, in my	iury et vork? Yes 2 No	28f. Location (City or To	now injury occurred  Street and Number of the Number of th	or Rural Route Number, Prince Route Number, Prince Route Number, Prince Route
	5		30. Name end eddres	of person who	completed caus	e of death (Iter	m 23a) (Type	Pript Ham	let All	1/24 21	Horge	15/2/1998
	Stat	e	31. Date filed (Month,	466	32. R	egistrar's Sign	ature					
	Registra		MUG 3 1	1998	Seren	19	· So	and 1				

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Phys · /Me Exan

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmitted event, The Mental Engineer man be notified at

**Physicia** /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

			Department of Certificate o				eg. No.	0 20	541
I. Decedent's Name (First, Middle, L	ast)					2. Dete of Deet	h		Time of Deeth
UNKNOWN	#98-1	13				Month MAY 2	Dey 8, 1998	Year	1735 PM
e Fecility Neme (If not institution, gr				4b. City, Tov	wn, or Loc	cation of Deeth		4c. County of Deeth	
GLEN COVE MARIN	IA			DAR	LING	TON	HAR	FORD	
5. Sociel Security Number 6.		ge (In yrs. lest bir	thday) If Under 1 Ye		24 Hrs. Min.	8. Dete of Birth (Month, Dey,	Vaarl	9. Birthplece Country)	Stete or Fore
UNKNOWN	¹□M 2XF UN	KNOWN	Yrs. Months Deg	ys Hours		UNKNOWN		UNKNOW	
Usuel Residence of Decedent  10e. Stete 10b. County		10c. City, Town	n aut nostina					404 5	alda Oisa I Isa
10e. Stete 10b. County		TUC. City, Town	n or Location						side City Llmi ☐ Yes 2 ☐ I
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0e. Street end Number			10f. Zip Code	9		10	0g. Citizen of	Whet Country?	
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11. Marital Status UNKNOWN	12. Was Deceden Armed Forces	?	13. Was Decedent of If Yes, specify C	of Hispanic Orig uben, Mexicen,	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		ce - Americen In ock, White, etc.	dien,
1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 if Yes, Give		1□ Yes 2□ N				Specif	y:	
		UNKNOWN	4		UNKN		16h Kind of D	WHIT!	
15. Decedent's E (Specify only highest g	rede completed)		Decedent's Usuei Occ (Give kind of work don life. DO NOT use ret	ne durina most	of working		TOD. MIND OF B	านอนเทยออ/เกเนนร์เก	
Elementary/Secondary (0-12) JNKNOWN	College (1-4or	5+)	UNKNOWN				IBRA	r. Th. T	
17. Fether's Neme (First, Middle, Las			UINNIVOWIN	18. Mothe	r's Name	(First, Middle, A	UNKNO Maiden Sumer	* ***	
UNKNOWN					NOWN				
19a. Informent's Name/Relationship	(Type, Print)	19h	. Mailing Address (Stre	City or Town	. Stete, Zip Cod	9)			
unknown	27	1.50	unknown				, , , , , , , , , , , , , , , , , , , ,		
20e. Method of Disposition		20b. Place of	Disposition (Name of	ala aa l		Date	20c. Location	- City or Town, S	Stete
4 Donetion 5 Dother (Special Supporting of Funeral Service Lice Ronald S		rector	22. Name end Add State Ana	atomy B	oard		. Balt:	imore St	reet
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31. Dete filed (Mont

29b. Signeture end title of certifier

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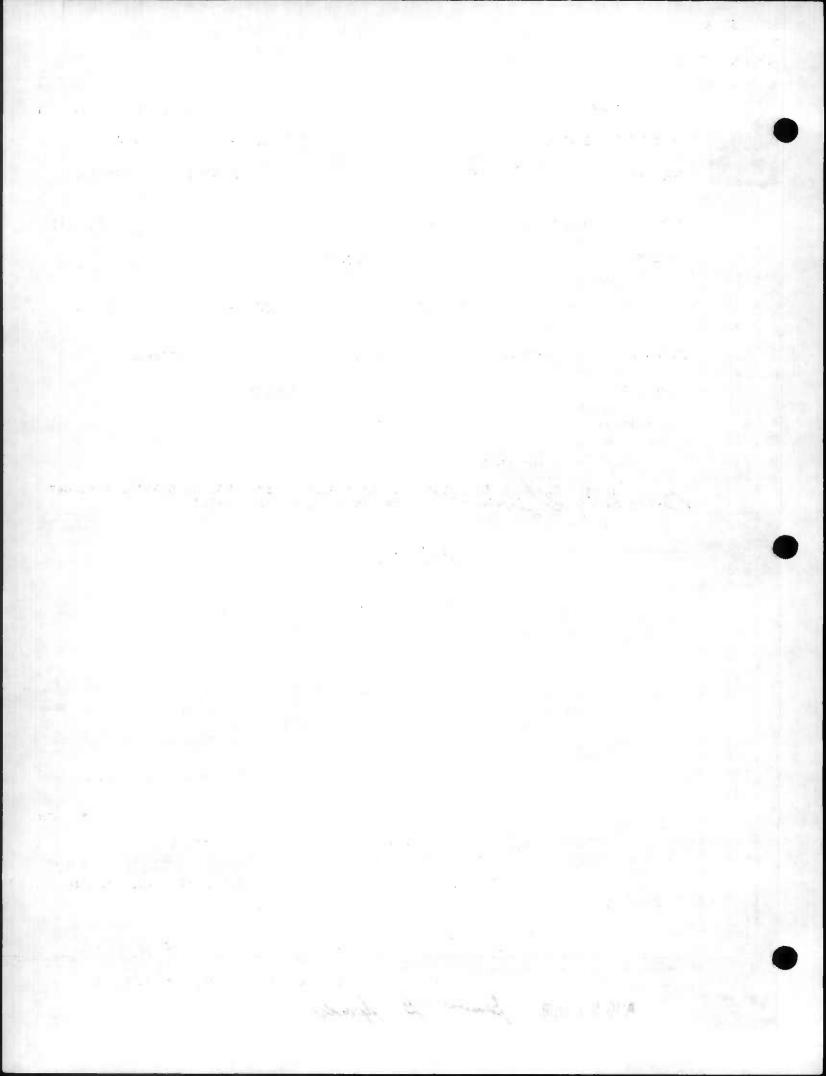
O.C.M.E

29d. Date signed (Month, Dey, Year) MAY 29, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrer's Signature oaks



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🚨 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dav Year **Physician** 4b. City, Town, or Location of Death 4c. County of Death Inkar Marjorie J. 4a Facility Name (If not institution, give street end number) 1139 /Medical **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months 1□ M 20 F Yrs. 219-20-0343 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No **Funeral Director** Md. Baltimore Reisterstown 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 1138 Berrymans Lane 21136 U.S.A. 14. Raca - American Indien, 13. Was Decedent of Hispanic Origin? (Specify Yea or NoIt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify: 12. Was Decedent Ever in U,S Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Dietery Supervisor Hospital 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Albert O. Gamber Helen Elizabeth Wiley 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Interment's Neme/Reletionship (Type, Print) Edward W. Unkart Husband 1138 Berrymans Lane, Reisterstown, Md. 21136 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Deer Park Cemetery 8/29/98 Reisterstown, Md 21. Signature of Fungal Service License 22. Neme end Address of Fecility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 23e. Part1, Enter the shock, or huar fail iplidetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final Sepsis diseese or condition resulting in deeth) C Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or as a consequence of) Due to (er as a consequenca of): Vuscular Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 15€Yas 2 No 3 Probably 4 Unknown Olcer disease 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ☐ Yes 20 No 1 TYes 2 □ No 25. Wes case reterred to medical 26. Place of Death (Check only one) Hospitel: 1 Sinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide

Physician/Medical Examiner Records, P.O. Box p Be Completed certificate director Certification: To this funeral After

**Funeral** 

Director

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r than "naturel", or items 23s or 28s-f ahore the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours efter

I Hygiene.

Peges 1 and 2 should be filled w tment of Heeith and Mentel Hygien tant: If Item 27 is marked other th ilury or other traumatic event, the

permit. Peges
Department of
Important: If It
any Injury or o

**Physician** /Medical

Examiner

21215-0020

Baltimore, Maryland

or Attending Physician:

of Vital Division To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Medical

HERBERT State AUG 9 1 Registrar

29a. Certifier

(Check only one)

30. Neries and address of person with completed ceuse of deeth (Item 23a) (Type, Print) TEH III

29c. License number

29d. Date signed (Month, Dey, Year)

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifi

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Deeth Month Day VALENTINE ANTHONY AUGUST 1 PM 28,98 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street end number) 4c. County of Deeth RANDALLSTOWN HOSPITAL CENTER NORTHWEST BALTIMORE If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) If Undar 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 6 Say Months Deys 10M 20F 63 SEP. 26, 1934 Yrs. 061-36-1240 Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No andalls IMORE 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 515 44 NNE HAUEN USA 13. Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) 12. Wes Decedent Ever in U,S. 14. Race - Amaricen Indian, 11. Merital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Detas: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) 6 NA FFICER MD State LORRECTIONAL 12+4 18. Mother's Name (First, Middle, Maiden Surnema). 17-Fether's Neme (First, Middle, Last) ERON MARU MHIER KERCU 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme Reletionship (Type, Print) 2124 bm. of 2124 3507 Lypne Haven prientine - Mute 2. ElEANOR 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20c. Location - City or Town, Stata Date 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State millsind 2501 M 862-6 bareison forest Vet. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Narch Funcka 21. Signature of Funeral Service Licensee WE WEST INC march 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest shock, or heen failure. List only one ceuse on each line. Dato, md, 21215 Approximate Intervel Between Onsat end Death Immediate Ceuse (Finel disease or condition resulting in deeth) CEREBRO VASCULAR ACCIDENT Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 1 Tyes 2 No 3™ Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Ware autopsy findings evailable prior to completion of ceuse of deeth? 24a. Wes en eutopsy DISEASE CORONARY ARTER 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 SInpatient 2 ER/Outpetient 3 DOA 28d. Describe how Injury occurred 27. Menner of Deeth 28b. Time of 28e. Date of Injury (Month, Dev Year) 28c. Injury et Work?

**Physician** /Medical \_x\_min\_r

Examiner

Physician/Medical

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Completed

Be

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Certification:

edical

1 Netural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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ms 23a or

Pages 1 and 2 should be filed within 72 hours after dea nen of Heelih and Mentel Hygiene. int: If Itam 27 is marked other than "natural", or itema-tury or other traumatic svent, its Medical Exerting.

permit. Peges Department of Important: If It any injury or or

Baltimore, Maryland 21215-0020

Directo

Funeral

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death

physician end the buriel-transit

signed by the e

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Attanding Physician: death. or Attance ofter deatl Diractor: within 24 hours of To the Funeral Completely filled

State Registrar

29b. Signature and title of certifier K.S.RAO.M.D.

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29c. Licansa numbar

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

D43462

1 ☐ Yes 2 ☐ No

AUGUST 28

MID

16.5. RAO. MI.D. 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

RANDALLSTOWN MORTHWEST HOSPITAL CENTER

31. Dete filed (Month, Day, Yeer)

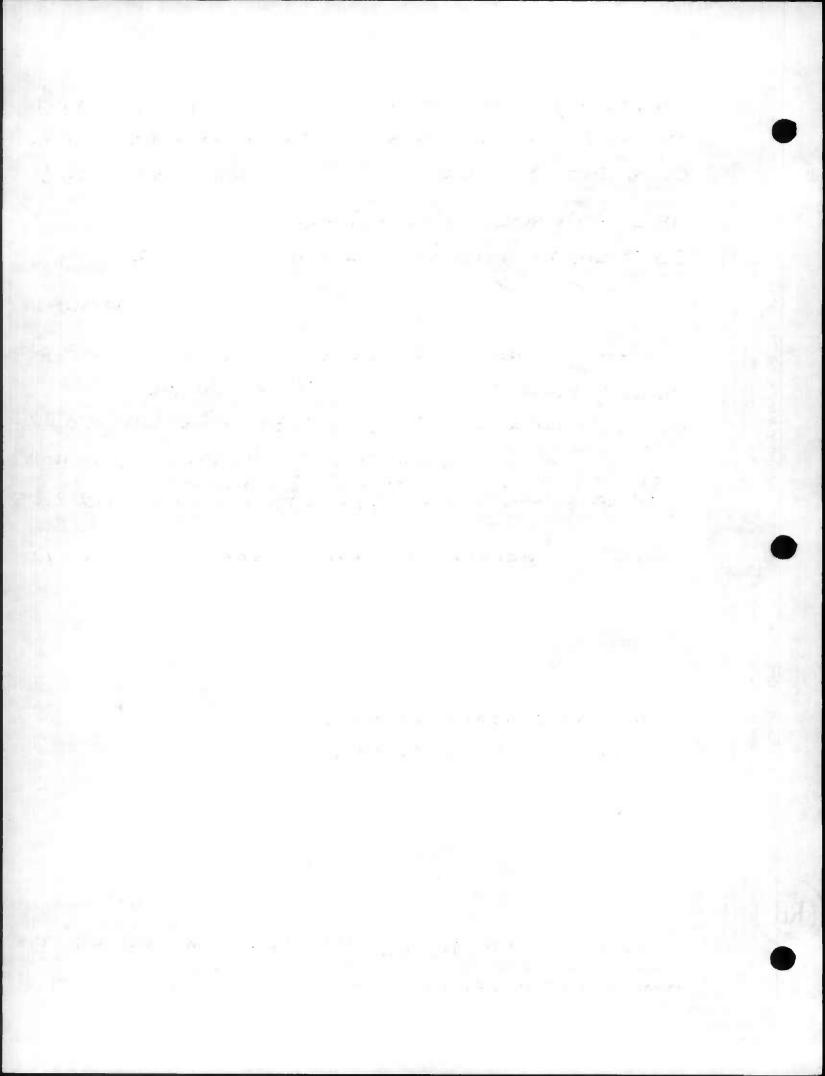
AUG 3 1 1998

5 Pending

investigation

6 Could not be determined

32. Registrer's Signatura chera



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend: #23a Part Ia Per MD Film G762 8-3 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Dey August 15, 1998 6:30 AM /Medical 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 102 E. Chestnut Hill Lane Baltimore Reisterstown If Under 1 Yeer | If Under 24 Hrs. | 8. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 □ M 2 □ F 179-22-1444 Yrs. Director Sept. 4, 1921 Pennsylvania Usuei Residence of Decedent deeth with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits lem 27 is marked other than "natural", or items 23a or 28a-f sho other treumatic event, the Medical Exeminer mast be notified at Maryland Baltimore 1 ☐ Yes 2 ☐ No Reisterstown Directo 10e. Street end Numbe 10f. Zlp Code 10g. Citizen of Whet Country? 102 E. Chestnut Hill Lane 21136 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours effer deet Department of Health and Mentel Hygiene. Important if them 27 is marked other than "natural" and within yer other traumatic averages. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritai Status Bleck White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Psychologist School School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surneme) Ernest Garfield Windle Sylvia Louise Moore 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15206 Catherine M. Salam/daughter 5700 Bunker Hill Street, Pittsburg, Pennsylvania 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 Donation 5 Other (Specify) 21 Speanure of Funer harrollognsee Wade, Director 22Stated Addato My Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Do not enter the mode of dying, such as cerdiec or respiratory errest, burn. List only one cause on each line. Approximete Onset and Deeth CANCER, PRIMARY **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner physiclen end s the buriel-transit tha daeth certificeta be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of) 80 980 jo signed by the a Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 □ Probably 4 □ Unknown þ bluods 24a. Wes an eutopsy performed? 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? Completed has certificate 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical examiner? 28. Plece of Deeth (Check only one) Hospitei: Other: 4 Nursing Home Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 26a. Dete of Injury (Month, Dey Year) 28b. Time of injury Certification: 28c. Injury et Work? Naturel 5 Pending investigation or Attending effer death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture and title of certife 29c. License number 29d. Date signed (Month, Day, Year)

W

\$2. Registrar's Signeture

se of deeth (Item 23a) (Type, Print)

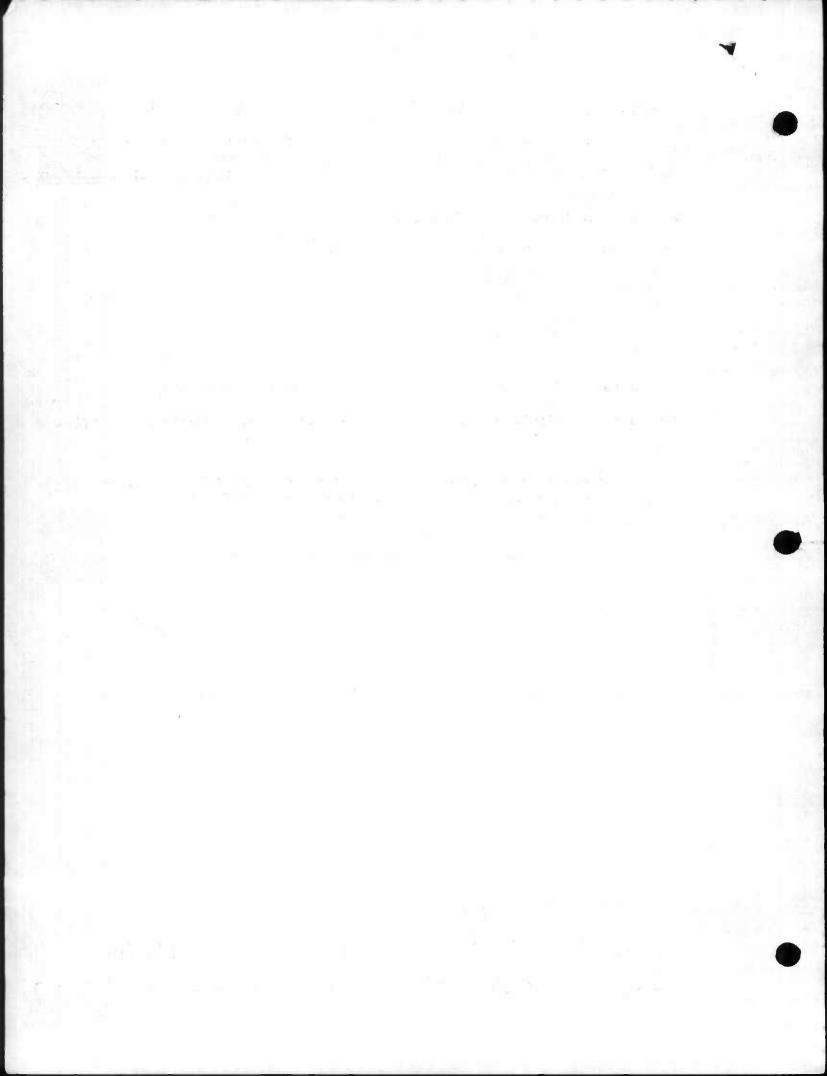
Charroses

035606

DR +45 avends meur modilis

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Dey, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth WILSON Month 30 PK **Physician** Mary 9 8-98 ugus /Medical 4a Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harborside Health Care at Harford Gardens N/A Baltimore If Under 1 Year Months Days 8. Date of Birth (Month, Dey, Year) May 26, 1908 If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (Stete or Foreign **Funeral** Hours 1□ M 2X F Mary land May 90 Director 212-68-3068 Usual Residence of Decedent the Marylend 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland N/A Baltimore City 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zin Code with Funerai 5919 Sefton Avenue 21214 United States 14. Raca - American In Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status efter 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specify: White p 3 XWidowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Peges 1 and 2 should be filed within 72 rant of Haalth and Mentel Hygiane. Int: If item 27 Is marked other than "natu Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home Ith and Mentel Hygia 27 Is marked other t r trsumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Carrie Mole Cornelius McNamara 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5919 Sefton Avenue Mrs. Joan J. Seeley / Daughter Baltimore, MD 21214 other 20b. Pleca of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State 0 permit. Pege Depertment of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 8/31/98 Baltimore, Maryland 21. Signature of Funeral Service Licansee Timothy S. 22. Name end Address of Facility Leonard J. Ruck, Harman Inc. Funeral Home 5305 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the distance, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failur. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es a consequenca of): Examiner Sequentially list conditions, If eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest to (or es e consequenca of) Physician/Medical the Due to (or as e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 A Unknown 1 Tes 2 No pA 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed need has 1 Yes 2 00 No 1 ☐ Yes 2 ☑ No certificata • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director. Be 25. Was case referred to medicel exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Dete of fnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) ð 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 To the 29d. Date signed (Month, Dey, Year) August 98 29c. License number 6 1

State Registrar

0

31. Date filed (Month, Dev, Yeer)

AUG 3

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3 (BEES (B) 560 ( 20 ell Kaven Burd, Baltimore, 32. Registrar's Signature

Rever

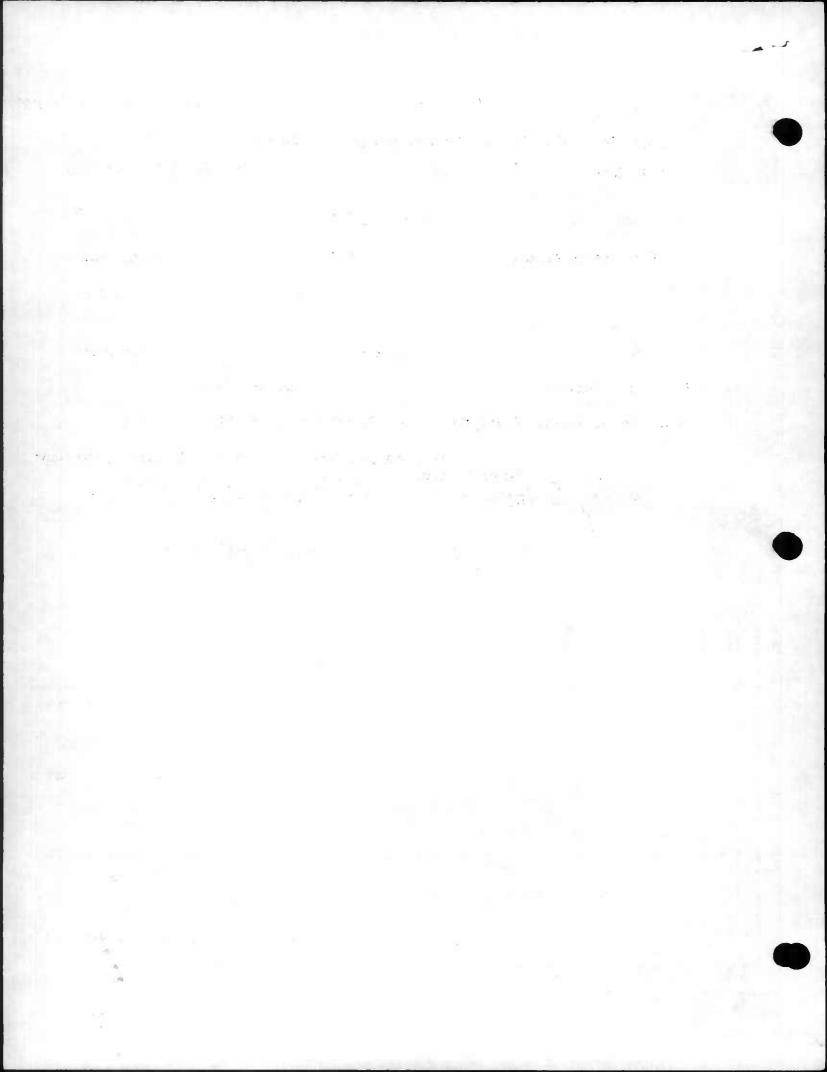
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**DHMH 16 Rav 6/95** 

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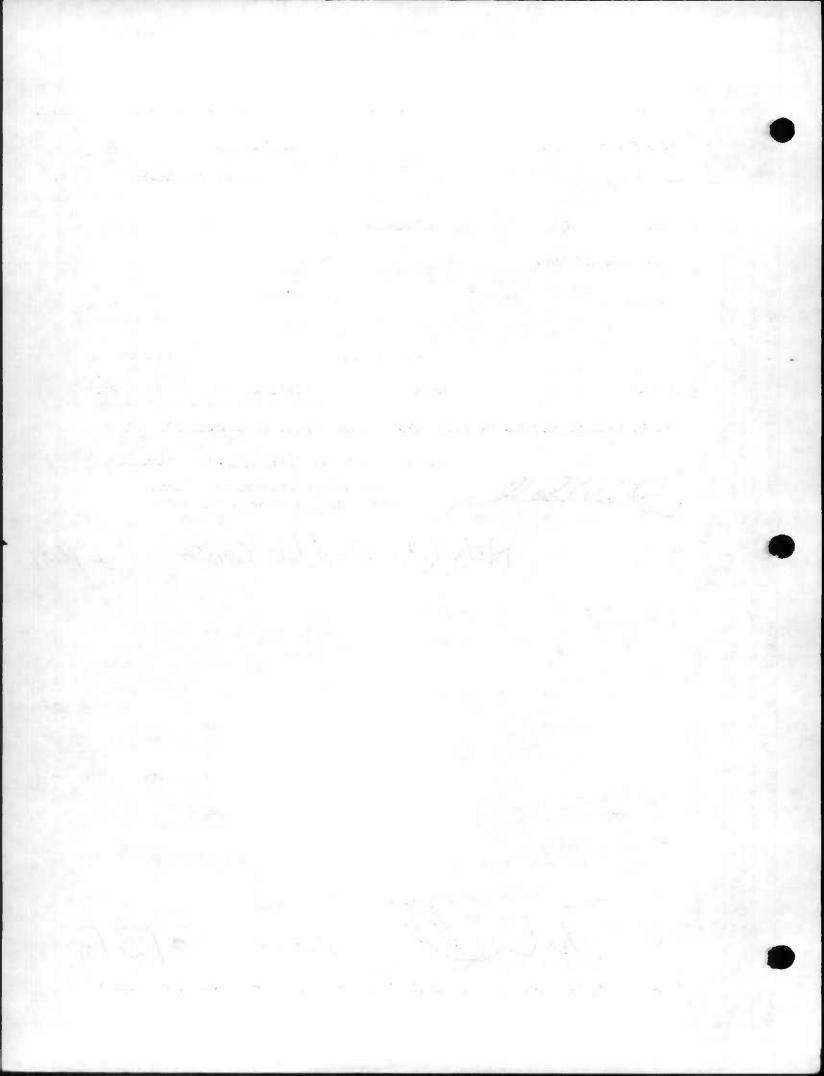
Division of Vital Records, P.O.



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Oldio of IVI		Certifica		Death		Reg. No.	) (	0046
Dhusisian	1. Decedent's Name (First, Middle, L	ast)					2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
Physician /Medical Examiner	PHYLLIS  4e Fecility Neme (If not institution, g.	L .		WISNER		4b. City, Town, or	August	27, 199	8	2:20 AM
Examiner	4209 Stanwood Av					P-1+	imoro		NT / 70	
Funeral Director	5. Social Security Number 6. 216-12-6716		e (In yrs. lest bi	Yrs. If Und Month	ler 1 Year s Deys				N/A 9. Birthplec Country,	ce (Stete or Foreign ) Md.
dend %	Usual Residence of Decedent  10e. Stete 10b. County		10c. City, Tow	vn or Location					10d.	. Inside City Limits
Man,	Md. N/A		Bal	timore						1⊠Yes 2□No
in the Mar or 28s-fs	10e. Street end Number				Zip Code			10g. Citizen of V	What Country	?
or theme 23st result of Funeral	4209 Stanwood Av 11. Maritel Stetus 1 Never Married 2 Married	e		13. Was Dec	21206 cedent of the cecify Cub	Hispenic Orlgin? (S en, Mexican, Puer	Specify Yes or No to Rican, etc.)		a - American ck, White, etc	
ural', o	3 ☑ Widowed 4 □ Divorced	Year or Detes:						Specify	Whit	
within than than within	15. Decedent's I (Specify only highest g	Education rade com <i>pleted)</i> College (1-4or 5	1+)			petion during most of wo d)	rking	16b. Kind of Bu		itry
e filed other vent,	8 17. Fether's Neme (First, Middle, Las	t)	He	ome mak	er	18. Mother's Na	me (First, Middle,	Own ho Maiden Sumen		
Mentai H Mentai H arked ott arked ott To Be	Edmund		Hurtt			Virgini	a		Parr	n
d 2 should be file th and Mental Hy 7 Is marked othe traumatic event.	19a. Informant's Name/Reletionship	(Type, Print)	198	b. Meiling Addre	ss (Street	t end Number or R		er, City or Town,		
1 end 2 Health em 27 i	Mr. L. Richard W	isner, Sr.,	/son 4	209 Star	nwood	Ave. Ba				
8 5 5 0	20e. Method of Disposition 12 Buriel 2 ☐ Cremetion 3		cemete	ery, cremetory o	r other ple		Date	20c. Location -		
- 두 등 등	4 Donetion 5 Other (Spec		Dulan			emorial pass of Facility	8/29/98	Timon	ium, M	id.
Depermination of the police of	THE COL	MA		Ruck	Tows	son Funer				
	art1. Enter the diseese, or con shock, or heart failure. List only	nplications that caused	the deeth. Do	not enter the m	York ode of dyi	Rd. TOWS	on, Md.	21204 rrest,	A	pproximete itervel Between
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting In deeth)	. Met	A Start Due to (or es e	tc B	low	11	Cana		2	years
death certificate be executed attending physician end ad for use as the bunel-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c		consequenca o						
the attendir the for use sician/A	Part II. Other significant conditiona	contributing to death bu	ut not resulting	In the underlying	g cause gi	ven in Pert I.	23b. Did	tobacco use co	ntributa to th	he cause of death
requires that the death certequires that the death certequiphould be deteched for use eted by Physician/W							10	Yes 2□ No	3 Probat	bly 400nknow
D 2 S S							24a. Wes	en eutopsy rmed?	eveile	eutopsy findings able prior to oletion of cause eth?
ysician: The law s certificate has b director, page 2 s G Be Compi							10	Yes 2 No	1 🗆 Y	res 28 No
clan.	25. Was case referred to medical examiner?	Hospital			104		eth (Check only o	one)		
4 E B	1 Yes 2 No	Hospitel: 1 Inpatie		utpetient 3 1	DOM		Home 5 Pescibe	denca 6 Oth		
offing I th. : After e funer	1 Pending 2 Accident investigation	28a. Date of Injur (Month, De)	Year)	Injury M	28c. Inju Wo	rk? Yes 2 No	280. Describe	now injury occur	160	
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To the Hospital within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifier (Check only 2 Medic 1	hysician: To the best of miner: On the basis of and manner sta	exemination at	geth occurre or investigation	ed et the ti	me, date end plece opinion, deeth occu	e, end due to the urred et the time,	ceuse(s) end me dete end plece,	enner es stete end due to th	ed. e cause(s)
within To the comple	29b. Signeture end title of certifier	11	11	/ 2	9c. Licen:	se number		29d. Date signe	d (Month, De	y, Year)
	1(1)	Cal	1/		134	2736		8/2	7/9	8
5	30. Name end eddress of person who	completed cause of de	eeth (Item 23e)	(Type, Print)					1.2	
		.D. Osler		Bldg.	7600	Osler Dr	. Towso	n, Md. 2	21204	
State	31. Dete filed (Month, Dey, Year) AUG 3 1 1999		er's Signeture	1		,		**		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Certific	ate of	Death	•	Reg. No.	2.0	741
Disconia	·	1. Decedent's Neme (First, Middle, Las	t)	-				2. Dete of De Month		Year	3. Time of Deeth
Physic /Medi	cai	Emily Ruth					45 City Town and	Augus	t 14	1998	0820
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Funeral		Kent & Queen  5. Social Security Number 6. Se		OSD1ta (In yrs. last bit		nder 1 Year	Chester If Under 24 Hrs.	town 8. Date of Bi	Ken		ce (State or Foreig
Director			□M 2[X]F	79	Yrs. Mon	ths Deys	Hours Min.	8. Date of Bi (Month, Di July 27,	1919	Country	ollege, PA
wo m		10a. Stete 10b. County		10c. City, Tow	m or Location					10d	d. Inside City Limits
Mary	to	Maryland Kent		Ch	nestert	ัดพท					1 X Yes 2 □ No
th the	Director	10e. Street end Number				. Zip Code			10g. Citizen of \	Whet Country	y?
th will		450 Heron Point				216	20		U.S.A.		
of a should be filed within 72 hours efter death with the Maryland of 2 should be filed within 72 hours efter death with the Maryland the and Mentel Hyglene.  7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercises must be notified as	by Funeral	11. Marital Status  1 Never Merried Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			ecedent of I- specify Cub- es 20 No	dispanto Ortgin? (Spen, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	ce - American ck, White, etc y: Whi	c.
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d within 72 ho plene.	Completed	Elementary/Secondery (0-12)	College (1-4or 5+	)			during most of work d)	ang			
Hiled w Hygien ther th		12	2	Но	omemake	er			Own H		
of 2 should be filed to a should be filed to an Mentel Hyg	Be	17. Father's Neme (First, Middle, Last)					18. Mother's Nam		, Meiden Suman	10)	
should be nd Mente marked umatic ev	1º	Clarence P. Sousle	-	101	Melling Add	Isaaa (Ctraat	Emily end Number or Rui	Adams	or City or Town	State 7in C	Sada)
od 2 shoth the end traum		Frank Albert Aten/	, , ,				nt Cheste				000)
iges 1 end 3 to 7 Hoalth If Item 27 or other tr		20e. Method of Disposition		20b. Plece 0	of Disposition ry, cremetory	(Neme of	nt cheste	Date Date	20c. Location -		n, State
bernit. Pages 1 er Department of Hea Mportant: If Item: Iny Injury or other		XXBurial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,						/. 1000	1/0 .1		
semit. Pa Separtmen mportant: any injury		21. Signeture of Funeral Service Licens		тиета	22. Nam	e end Addre	August 2	4, 1998	Southe:	rn Pin	es, N.C.
Depa impo		1 Kiel O	2/11	a:	)Fellow	s, Helf	enbein & Ne	wnam Fun	eral Home,	P.A.	
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Physician		shock, or heart feilure. List only o	ne ceuse on each line							lr C	ntervel Between Onset end Death
/Medical		Immediate Cause (Final disease or condition	CERER	Dava	CCIAI	An	ACLI	DONT	-	7	dan
Examiner		resulting In death)		ue to (or as e			n cci,	16.01			saup
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ficete be ex physician ss the buriel		Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	· HYPE	RTEN	SIVE	CA	RDIOVA	SCUL	AR DISE	ASE :	> loyen
phys the	edicai	thet initiated events resulting in deeth) Last		ue to (or es e							1372
	5		d								
eath cerr attendin	ciar										
The law requires that tha death ce are the best been signed by the attending page 2 should be detached for use	Physician/	Part II. Other significant conditions co.	ntributing to death but	not resulting i	n the underlyi	ng ceuse giv	en in Pert I.				he cause of death
thet ned be deft	by P				·			םי ו	Yes 2 No	3 Probai	bly 4 🗆 Unknow
w requires the	8								en eutopsy	24b. Were	e eutopsy findings able prior to
aw re	Completed	v						pen	ormed?	comp	pletion of cause
The lav te hes age 2	EO							10	Yes 200 No	101	Yes 20 No
iclan: The certificate rector, pag	Bec	25. Was cese referred to medical					26. Piece of Deal				-74.10
ysici is cel	ToE	exeminer? 1 Yes 2 No	Hospital:	2 □ ER/O	utpetient 3	DOA Oth	or.		idence 6 □Oth	er (Specify)	
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Deeth  1 Naturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey )		Time of Injury M	28c. Injui Wor	y et rk? Yes 2 □ No	28d. Describe	how injury occur	red	
or Attending Physician: The law requires the after data.  Signal data.  In by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, fe (Specify)	erm, street, fa	ctory, office			(Street end Numb wn, Stete)	er or Rural F	Route Number,
Hospital 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	elclen: To the best of oner: On the basis of e	xaminetion en	e, deeth occur d/or Investiga	red et the tir	me, dete end plece, pinion, deeth occur	end due to the	ceuse(s) end me date end place,	enner es stet	ed. ne ceuse(s)
ithin ithe	Mec	29b. Signeture and title of certifier	end menner state	10.		29c. Licens	e number		29d. Date signe	d (Month De	ev. Year)
F 3 F 8		1 Hin A	Mm	-		-	+1587		6//	4/9	
	20	20 Name and address of the same	- Indiana - Indi	Ab //Ac 22 :	Contract Since	V	100/		8/1	717	8
		30. Name and eddress of person who con Helen A. Noble 122	Speer Road S			town M	21C Inc. [270]	20			
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar		1	-		۵			
Registr	ar	31. Date filed (Month, Day Year) 7 1	998	eva	19.	Loan	1/21				

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State of Maryland / Department of Health and Mental Hygiene

Dhugie	ion	1. Decedent's Name (First, Middle, La	est)	191	ertificate of		2. Dete of Deetl		3. Time of Dea
Physici /Medi		Bruce Lawrence B	rown					20, 1998	
Examir		4a. Fecility Neme (If not institution, give				4b. City, Town, or L		4c. County o	
		Kent & Queen Ann	ne's Hospi	tal		Ches	stertown	Ke	ent
Funeral Director		5. Social Security Number 6. S 359–26–9119	Sex 7. Ag	ge (In yrs. lest birthda 4 Yrs.	Months Days		8. Dete of Birth (Month, Dey, July 18,	Year) 1934	9. Birthplece (State or For Country) Illinois
M 111		Usuei Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Lin
He de	ctor	Maryland Ken	it	Che	estertown				1 Yes 2 □
or 28	Oire	10e. Street end Number			10f. Zip Code		10	Og. Citizen of Wi	het Country?
238	a	208 Waldo Drive			21	.620	U	Inited S	tates
"natural", or items 23a or 28a-f ahow adical Examiner must be notified at	by Funeral Director	11. Marital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give Year or Detes:	Ever in U,S. 1 No. 1956–66	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		pecify Yes or No- Rican, etc.)	Bieck	- Americen Indian, , White, etc. White
natur	Completed	15. Decedent's Et (Specify only highest gre Elementary/Secondary (0-12)	College (1-4or	16e. De (Gi life	cedent's Usual Occup ive kind of work done b. DO NOT use retire	petion during most of worked)	king	16b. Kind of Bus	iness/Industry
other than		12	4	Soft	tware Engi			Softwar	
\$ q	Be	17. Father's Name (First, Middle, Last,					e (First, Middle, M	falden Sumeme	)
	To	Walter Brown				Hazel I			•
10 00 E		19a. Informent's Neme/Reletionship ( Carol Boasi Brow			Waldo Dri				
item 27 other tr		20a. Method of Disposition	II ( WIIE .	OOL Diese of Die	annelian (Alama of				d 21620
tant: If it		1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	ion Cente	r, LLC	Cheste	r, Maryland			
important in once.		21. Signeture of Funeral Service William L. Ki	MAX	00937	22. Name end Addre Fellows, H 30 Speer	elfenbein	, & Newn	am Fune	ral Home, P
/sician ledical		23a. Pert1. Enter the disease, or conshock, or heart failure. List only				ng, such es cerdiac	or respiretory arre	est,	Approximete Intervel Between Onset end Deeth
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iclan		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	C						
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for us	Physician/M		d						
the e	ysic	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause giv	ven in Pert I.	23b. Did tol	pacco use cont	ribute to the cause of de
gned by the ettendin be deteched for use	by Phy		LPELL!				1□ Ye	* 250 No :	3 Probably 4 Unkr
has been signed t ge 2 should be det	Completed						24a. Wes en perform		24b. Were eutopsy finding eveileble prior to completion of ceuse of deeth?
pege	000						1 ☐ Ye	s No	1 ☐ Yes 2 No
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Ø 10	To	examiner?	Hospitel: Impatie	nt 2 ER/Outpat	ent 3 DOA Oth	or.	me 5 Resider		(Specify)
r: After th		27. Manoer of Deeth  1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Inju (Month, De	ry 28b. Time	Wor		28d. Describe how		
ral Diracto	Certification:	3 Suicide 6 Could not be determined	building, etc	10 401			City or Town,	Stete)	or Rurel Route Number,
he Funer pletely fill	edicai	29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 1	ysician: To the best of liner: On the basis of and menner sta	examinetion end/or	ath occurred et the tin Investigation, in my o	ne, date end place, pinion, deeth occur	end due to the cer red at the time, de	use(s) end menr te end place, en	ner as steted. d due to the ceuse(s)
		29b. Signature end title of certifier	29c. Licens	29c. License number		d. Date signed	(Month, Dey, Yeer)		
To the Fur	Σ	A A	1, 1						1 -
	<b>≥</b>	30. Name end eddress of person who o	the n			+1587		8/	20/98

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

		A Decederate News (See Middle 1		C		of Death		Reg. No.	26549
Physic	ian	1. Decedent's Name (First, Middle, Last					2. Data of Dea Month		3. Time of Death
/Med		Patricia A. Barre					August	20, 1998	2:30 p.m.
Exam	ner	4a. Facility Name (If not institution, giva					Location of Death		
6 0		Duck Neck Camp Gro			. Williada a		tertown		n Annes
Funera Director	_	5. Social Security Number 6. Se 182–42–6347	7. Age (In yn 47)	s. last birtho	Months	Year If Undar 24 Hr. Days Hours Mir		r, Year)	Birthplace (State or Foreign Country) hiladelphia, F
land m ow		10a. Stata 10b. County	10c. (	City, Town o	r Location				10d. Inside City Limits
the Mary 28a-f sh	Funeral Director	Pennsylvania Phi	ladelphia I	Philad	lelphia	and a		10g. Citizen of Wha	XXYes 2 □ No
3e or	0	348 Winton Street				148		United	,
deatl	Dera		12. Was Decedent Ever In	U,S. 1		nt of Hispanic Origin? ( y Cuban, Mexican, Pue	Specify Yes or No-		American Indian,
21215-0020  d within 72 hours after death with the Maryland giene. If then "natural", or flems 23e or 28s-f show it has been examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes   \$\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		If Yes, specify		rto Rican, atc.)	Specify:	White, etc. White
21215-002 I within 72 hours iene. than "natural", the Medical Exe	Completed	15. Decedent's Edu (Specify only highest grad	ication la complated)	16a. De	ecedent's Usual	Occupation done during most of we retired)	orkina	16b. Kind of Busin	ness/industry
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To the Hospital or within 24 hours eft To the Funeral Dir completely filled in	edical (	29a. Certifier (Check only one)	sician: To the best of my kn per: On the basis of examin manner stated.	owledge, de ation and/or	eeth occurred at r investigation, in	the time, date end place my opinion, death occ	e, end due to the curred at the time, d	ause(s) and menne ate and place, and	er es steted.  due to the cause(s)
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	1	30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Tvr	pe, Print)			21	
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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AM PSON 0 08 0 G 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Golden Oaks Nursing Home Laurel Prince Georges If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2⊠F Months Days Yrs. May 19, 1906 North Dakota 502-16-3112 92 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5837 Barnwood Place 21044 United States 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Novidowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (First Middle Maiden Sumeme) 17. Father's Name (First, Middle, Last) Lars Tiegen Gurdrin unknown 19b. Malling Address (Street end Number or Purel Route Number, Cify or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Greta Paulson/Daughter 5837 Barnwood Place Columbia, Maryland 21044 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 Burial 2 Dicremetion 3 Removal from State 8-10-98 Catonsville, MD 4 □ Donation 5 □ Other (Specify) Metro Crematory 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Service Licansee we a -4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Sepsis Immediate Cause (Final disease or condition resulting in deeth) hours Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown rgin syndrome 24a. Was an autopsy performed? 24b. Were autopsy findings aveilable prior to KINSONS completion of cause of death? 1 ☐ Yes 28 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed physician end P.O. Box 68760, S USe for ed by tha a signed t Division of Vital Records, pege 2 s has certificata or Attending Physician: funeral director, After this aftar death. Director: Aft filled in by

Examiner Physician/Medical ð Completed Be Certification: To

**Physician** 

/Medical

Examiner

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permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryla Department of Health end Mentel Hygiana. Important: If flem 27 is marked other than "natural", or items 23a or 28s-1 show any Injury or other traumatic event, the Mexical Example Injury or other traumatic event, the Mexical Example Injury or other traumatic event.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0020

29e. Certifier edicai (Check only one)

3 Suicide

4 ☐ Homicide

31. Date filed (Month, Day, Year)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated.

29b. Signaty

29c. License number 25 430 or margoles 29d. Date signed (Month, Dey, Year)

30. Name and eddress of p no completed cause of death (Item 23a) (Type, Print)

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State Registrar

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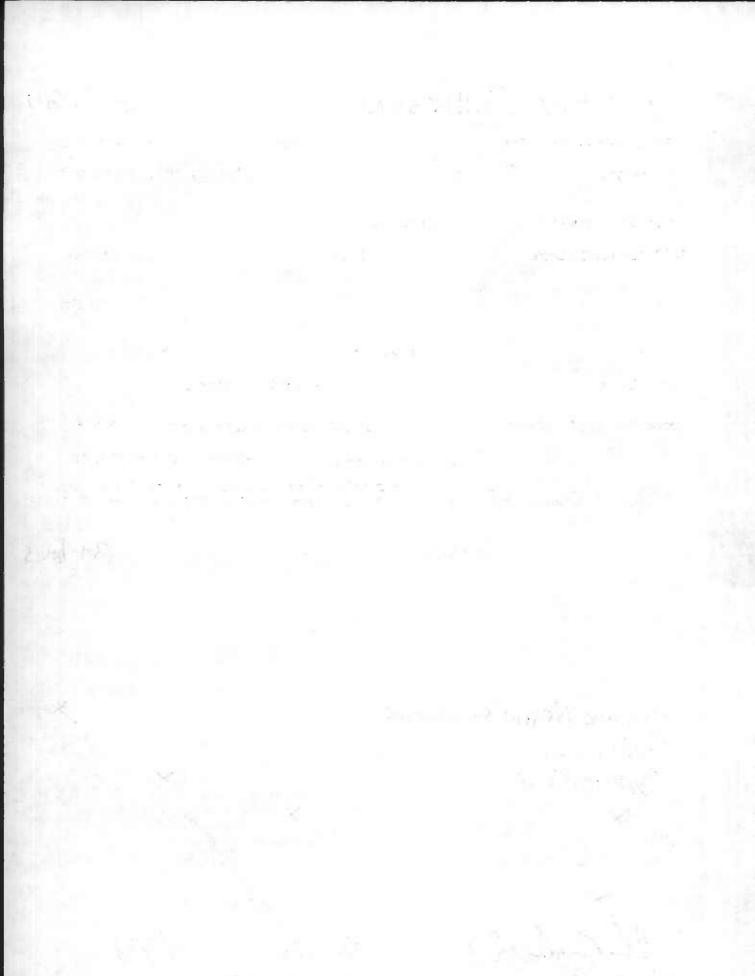
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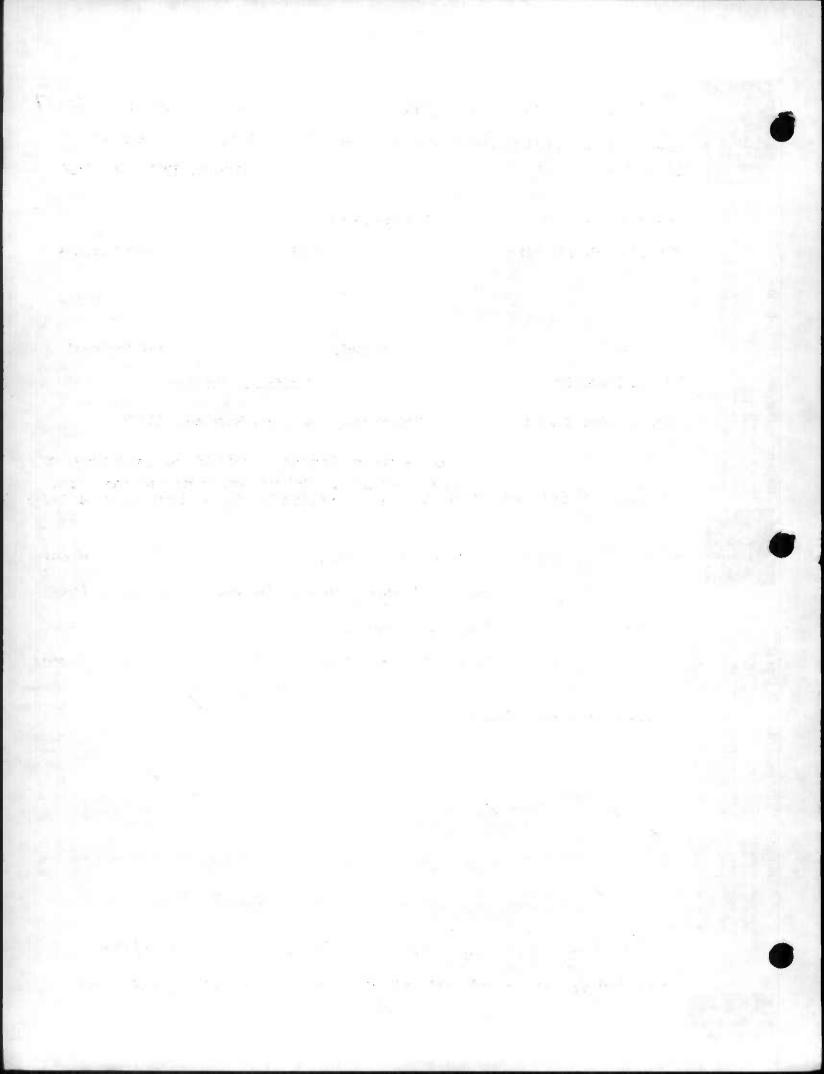
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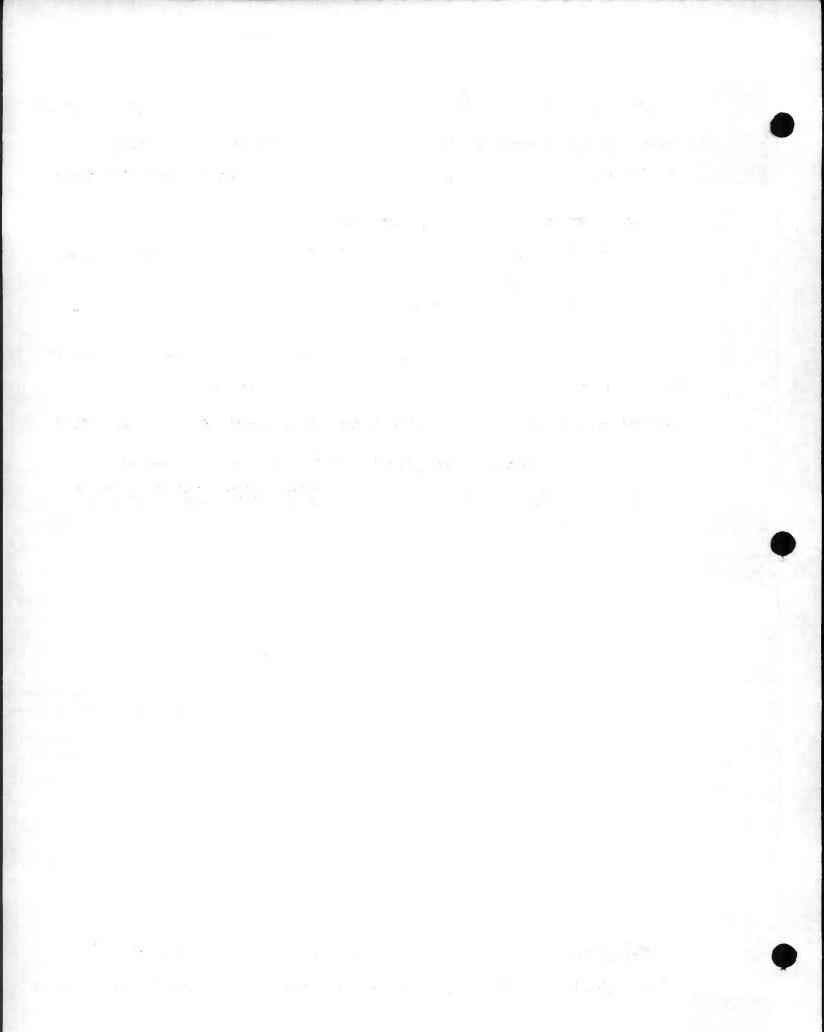
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First Middle Last) **Physician** 2027 13aker AUgust /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Cococol Hospital C Columbia Howard 5. Social Security Number County If Under 24 Hrs. 8. Date of Birth (Month, Dey, Jan 29, 6. Sex 1 M 2 □ F Birthplece (State or Foreign Country) **Funeral** Days Months 219-32-5869 61 Maryland Director Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10e State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3787 Old Columbia Pike 21043 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 □Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Self Employed 18 Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) John D. Baker Sr. Emeline T. Mercier 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) John D. Baker III/Son 2903 Freeway Arbutus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Good Shepherd Cemetery 8-17-98 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. llusa Co 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical Respiratory Failure Heeks Examiner Due to (or as a consequence of): Examiner Obstructive Pulmonary Disease Chronic Years and I-trensit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): physician at the burial-Records, P.O. Box 68760. Weeks Aspiration Due to (or as a consequence of): Physician/Medical attending ph Head and Neck Carner Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the a 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Gastrumtestinal bleeding 5 24b. Were autopsy findings available prior to completion of ceuse of death? been sig 24a. Was an autopsy performed? Completed has ils cartificata ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was cese referred to medicel examiner?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L<sub>o</sub> 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Aftar 5 Pendino To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8M Carlam, MD Slor Clivitie D53636 10 30. Name and address of person on who completed cause of death (Item 23a) (Type, Print) 3460 Elliwith Center Drive, Elliot City MD Bishoff carlson, MD AUG 32. Register's Signature 1998

State Registrar



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24e. Was an autopsy performed?  24e. Was an autopsy performed?  24e. Was an autopsy performed?  25e. Was case referred to medical axaminar?  25e. Was case referred to medical axaminar?  25e. Was case referred to medical axaminar?  25e. Place of Daath (Chack only one)  27e. Mannar of Death (Specify)  27e. Mannar of Death (Specify)  27e. Mannar of Death (Specify)  28e. Data of Injury at Work?  28e. Data of Injury At homa, farm, streat, factory, office  28e. Data of Injury At homa, fa	0 8	ysi	Part II. Other significant conditions	contributing to death but not re	asulting in t	ha <i>u</i> ndarlying	causa giv	an in Part i.				1
24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  1   Yas   2   No    25c. Was case referred to medical axaminar?  25c. Vas case referred to medical axaminar?  26c. Deta of Injury at Work?  27c. Manner of Death (Check only one)  28d. Dascribe how injury occurred at Morth. Das Call of Chy or Town, State)  28d. Dascribe how injury occurred at the tima, data and placa, and due to the cause(s) and manner as stated.  29d. Certifier  29d. Data signed (Month, Day, Year)	a deta								_   1	Yes 2 No	3   Probabi	y 42 Unknow
1   Yas 2   No   1   Yas 2   Yas 2   No   1   Yas 2   No   No   No   No   No   No   No	s been sig										availat	bla prior to letion of causa
25. Was case referred to medical axaminar?  100 as 2 No  Hospital: 1 Inpatiant 2 ER/Outpatient 30 DOA  Other: 4 Nursing Homa 5 Residence 8 Other (Specify)  27. Manner of Death 100 Natural 5 Panding investigation 3 Sulcida 6 Could not be determined  28. Place of Death (Chack only one)  28. Injury at Work?  M 1 Yes 2 No  28. Injury at Work?  M 1 Yes 2 No  28. Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury At home, farm, streat, factory, office  28. Injury at Work?  M 1 Yes 2 No  28. Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Place of Injury at Work?  M 1 Yes 2 No  28. Critiler (Check only or Town, State)  28. Critiler (Check only or Town, State)  29. Certifier (Check only or Town, State)  29. Signature and title of certifier  29. Certifier (Check only or Town, State)  29. Signature and title of certifier  29. Certifier (Check only or Town, State)  29. Data signed (Month, Day, Year)  30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print)  31. Data filled (Month, Day, Year)  32. Register's Signature	ed e ha	E o							10	Yas 210 No	1 D Y	as 2□ No
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State   Stat	is ce	0		Hospital: 1 Inpatiant 2	□ ER/Outp	eatient 300	Oth	ar.			nar (Specify)	
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29a. Certifiar (Check only one)  29a. Certifiar (Check only one)  29a. Certifiar (Check only one)  29b. Signatura and titla of certifiar  29c. Licansa number  29c. Licansa number  29d. Data signed (Month, Day, Year)  30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)  31. Data filled (Month, Day, Year)  32. Registrar's Signatura	s after dea i Director	Sertifica	3 ☐ Sulcida 6 ☐ Could not	28e. Place of Injury - At	Se. Place of Injury - At homa, farm, streat, factory, office			28f. Location (Streat and Number or Rural Routa Numb City or Town, Stata)			outa Number,	
30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)  State DiGram   Dot Littur Paritur Parkury Columbia, MD Huyy  31. Data filed (Month, Day, Year) 32. Register's Signature	24 houn Funera etely fille		(Check only 2 Medical Exa	minar: On tha basis of axami	nowledge, nation and/	daath occurred or invastigatio	d at tha tir n, in my o	ma, data and pla pinion, death oc	ca, and dua to the curred at the time	cause(s) and ma , data and place,	annar as state and dua to the	ed. a cause(s)
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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth August **Physician** 1998 ANNA M. BIANCO 10:45 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner St. Joseph's Nursing Home Catonsville Baltimore If Under 24 Hrs. 8. Dete of Birth
Hours Min. Sept. 24, 1906 5. Sociel Security Number 6. Sex If Under 1 Year 9. Birthpiece (State or Foreign Country)
Italy 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 XF Months Deys 91 Yrs. Director 217-48-2737 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Experiments. 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Ellicott City 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zlp Code 3230 West Springs Drive 21043 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Emidio Mattia unknown Agnes 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paulina Collins/Daughter 3230 West Springs Drive Ellicott City, MD 21043 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 8-21-98 Baltimore, Maryland Lorraine Park Cemetery 22. Name and Address of Facility. Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funerel Service Licensee 23e. Pent1. Enter the disease, or compilections that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart lailure. List only one cause on each line. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel diseese or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? w/lywidin 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings evellable prior to completion of ceuse of death? Renal failure. 24a. Wes en eutopsy performed? Completed peed Is certificate hes director, page 2 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) funerel 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 XNaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined n 24 hours after der Ne Funeral Director Dietely filled in by th 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier edicai 1 🗗 Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. completely ☐ Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. (Check only one) To the within 2 29c. License number Fuderale At Baltimizin 30. Name end eddrage of person who completed cause of deeth (Item 23a) (Type, Print) Alesandro 112 31. Dete filed (Month, Day, Year) 32. Roomer's Signeture State AUG 20 1998 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death **Physician** AUGUST 11ay 1998ar 0140 BESSIE ANN BAUGHER /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth FREDERICK **Examiner** FREDERICK NORTHAMTON MANOR NURSING CENTER 7. Age (In yrs. lest birthday) If Undar 1 Year If Undar 24 Hrs.

North Deys Hours Min 8. Data of Birth (Month, Dey, Yeer) NOV 23, 1917 9. Birthplace (Stete or Foreign **Funeral** 236-64-7850 1□M 20 F MARYLAND Yrs. Director Usual Residenca of Decedent death with the Marylend 10a State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar inset be notified at 10c. City, Town or Location 10d. Inside City Limits FREDERICK FREDERICK XXYes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. 200 EAST 16TH STREET Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indien, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No If Yes, Give X altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Year or Dates: Be Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOMEMAKER 6th Department of Heelth and Wantel Hydi Important: If Item 27 is marked any injury or other 17. Fether's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meidan Surname)
ELLA RAMSBURG HARRY WATSON 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State Zip Code) 819 E. POTOMAC ST. BRUNSWICK, MD 21716 JUNE R. ANDERS (DAUGHTER) 20b. Placa of Disposition (Name of cemetery, crametory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) LEWISTOWN CEMETERY 8/13/98 FREDERICK CO. MD. 21. Signature of Filteeral Service Lice ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. MARKET ST. FREDERICK, MD. . Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate **Physician** /Medical Immediate Ceuse (Final D. sease Years disease or condition resulting in deeth) art, NSIN'S **Examiner** Due to (or es e consequença of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the buriel-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequenca of): P.O. Box 68760, Due to (or es e consequenca of) use es guipo for u signed by the e Pert II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Denentia Records, þ Completed 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Wes en eutopsy performed? pege 2 certificate 1 🗆 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4M Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this funeral 28a. Dete of Injury (Month, Day Yeer) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) AUGUST 12, 1998 M Tolino MD MD051610 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1475 MICHAEL A. TOLINO, MD TANEY AVE. FREDERICK, MD 21701

State Registrar 31. Dete filed (Month, Day, Year)

32 Registrer's Signature

(4)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth August 14, 1998 **Physician** MILDRED K. CONNELL 10:30 am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Suburban Hospital Bethesda Montgomery 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthptece (State or Foreign Country) **Funeral** Months Days Hours 1□M XXF 107-36-1565 89 Yrs. Director Apr. 9, 1909 New York Usuel Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location rthan "natural", or Items 23a or 28a-f show the Medical Expressor nest be notified at 10d. Inside City Limits 1√Yes 2□No Director New York Oueens Forest Hills 10e, Street end Number 10f. Zip Code 10g. Cittzen of Whet Country? 72-24 Juno Street 11375 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritat Status 72 hours efter 1 ☐ Yes 2 ☑ No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than Irry or other traumatic event, Ira Ma Elementery/Secondery (0-12) Cotlege (1-4or 5+) years Social Worker Board of Education Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Peter King Catherine Connelly 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Kevin M. Connell 72-24 Juno Street son Forest Hills, New York 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Aug 22, 1 ☐ Burial 2 ☐ Cremetion 3 € emovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Depertment of Important: If any injury or once. 1998 St. Mary's Cemetery Flushing, New York 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility
Donaldson Funeral Home, P.A. 1 313 Talbott Avenue Laurel, Maryland 20707 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hear reliure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical fmmediete Ceuse (Finel diseese or condition resulting to deeth) Cardiopulmonary Arrest Examiner Immed. Due to (or es e consequence of): Examiner Subdural Hematoma 48 hours Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown atrial fibrulation Records. P 2 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? page 2 this certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Inpetient 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Atter 1XXVaturei 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homtcide ò XXCertifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a, Certifier Medical (Check only one) To the Ho within 24 t To the Fur 29b. Signeture end title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) D 43691 August 14, 1998 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Washington Circle #306 Washington, D.C.

Souks

20037

**DHMH 16 Rev 6/95** 

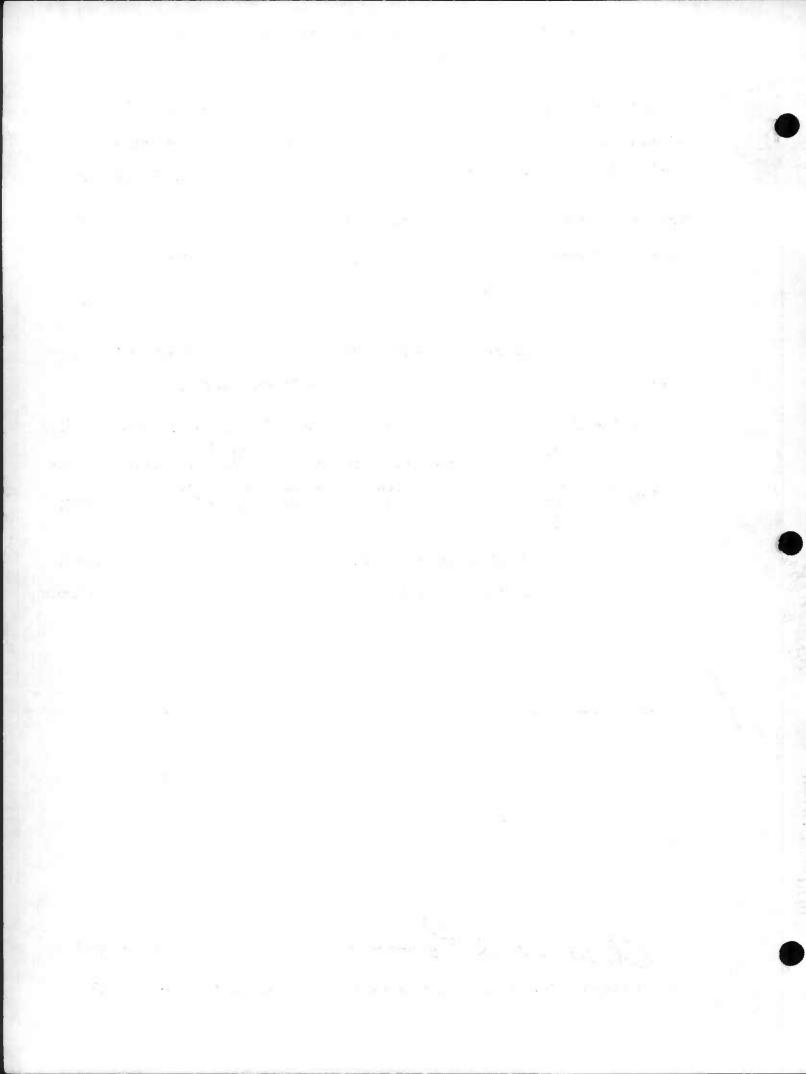
State Registrar Dr. Alexandro 31. Dete filed (Month, Day, Year)

AUG 2 0 1998

Alexandros Powers

32. Registrar's Signature

n, Idrad (brine,



State of Maryland / Department of Health and Mental Hygiene

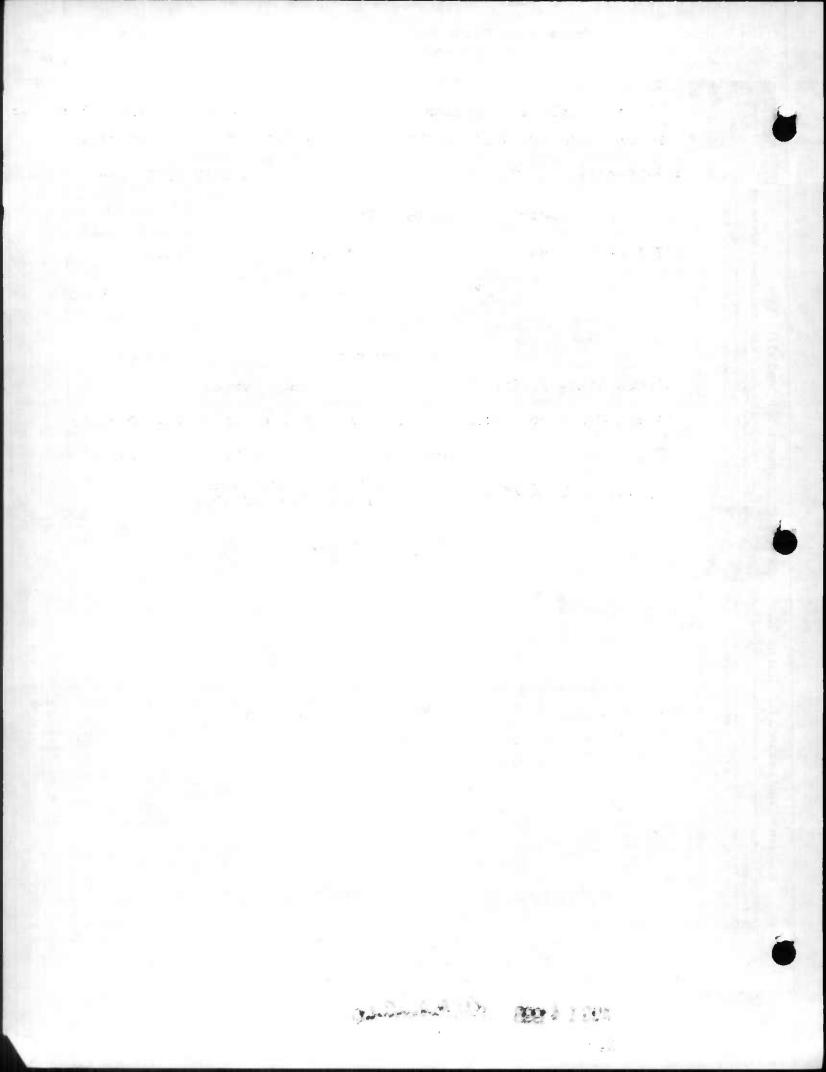
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ζ.	Examiner	4e Fecilify Neme (	If not institution, gi	ve street end nu	umber)			4	4b. City, To	wn, or L	ocation of Deet	h 4c. C	ounty of Deetl	1
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Г	Funeral	5. Social Security I		Sex	7. Age (In yrs. Is	ast birthday)	if Under					9. Birtl	hplece (State or Foreign	
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	iter death with the Marylend ritema 23a or 28a-f show viner must be notified at Funeral Director	11. Maritel Status		12. Wes Dec	cedent Ever in U,S	S. 13. 1	Wes Decede	ent of H	lispenic Orl	lgin? (Sp	pecify Yes or No Rican, etc.)	- 14	Race - Ame	
0	fler of riber	1 Never Man	ried 2 Married	Armed F	orces?						Rican, etc.)		Bleck, White	
21215-0020	72 hours efter netural; or ite		4 ☐ Divorced	If Yes, G Yeer or I	ive Dates: WWI	I	1 ☐ Yes 2	& No	Specify:			S	pecify: W	hite
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a	id be fill he fill he det out of the out of	Roland	Robert	Cartrig	ght				He	len	M. Be	resfo	rd	
Maryland	2 should be to and Mentel I a marked of reumatic eve	19a, Informent's N	lame/Relationship			19b. Mailir	na Address	(Street	end Numb	er or Rui	rel Route Numb	er, City or 1	own, Stete, Z	(ip Code)
S	s 1 and 2 should be filed within 72 hours efter death with the Maryler if Health and Mentel Hygiena. Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumstic event, the Medical Exercitor must be notified at To Be Completed by Funeral Director		R. Carti		Wife						ederic			21703
é,	permit. Pages 1 and 3 Depertment of Health Important: If Item 27 I any injury or other tri anges.	20e. Method of Dis			20b. PI	ece of Dispo	sition (Nem	e of			Dete	20c. Loca	tion - City or	Town, Stete
Baltimore,	0 0	1 ⊠ Burial 2	☐ Cremation 3 [		Stete	metery, crer			,		0/15/00			
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Sal	permit. Pag Depertment Important: I any Injury o	21. Signature of Fi	uneral Service Lice	nsee /	1		Neme end				TD. A	Farm -	. 1 II.	
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P.O.	tha d y the ichec	Part II. Other signi	ficant conditions	contributing to d	death but not resu	iting in the u	ndenying ca	use giv	en in Perti	1.			-	to the cause of death?
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Division	tal or Attending P is effect death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined	206. PIGO	e of injury - At hor ling, etc. (Specify	me, farm, sti	eef, factory,	office				(Street end	Number or Ru	irel Route Number,
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	he Hospit in 24 hour he Funera pletely fills	(Check only one)	2☐ Medical Exa	miner: On the b end mer	pasis of examinati nner stated.	ion end/or in	vestigetion,	in my o	pinion, dee	eth occur	rred et the lime	date end p	lace, and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 9 8 26557

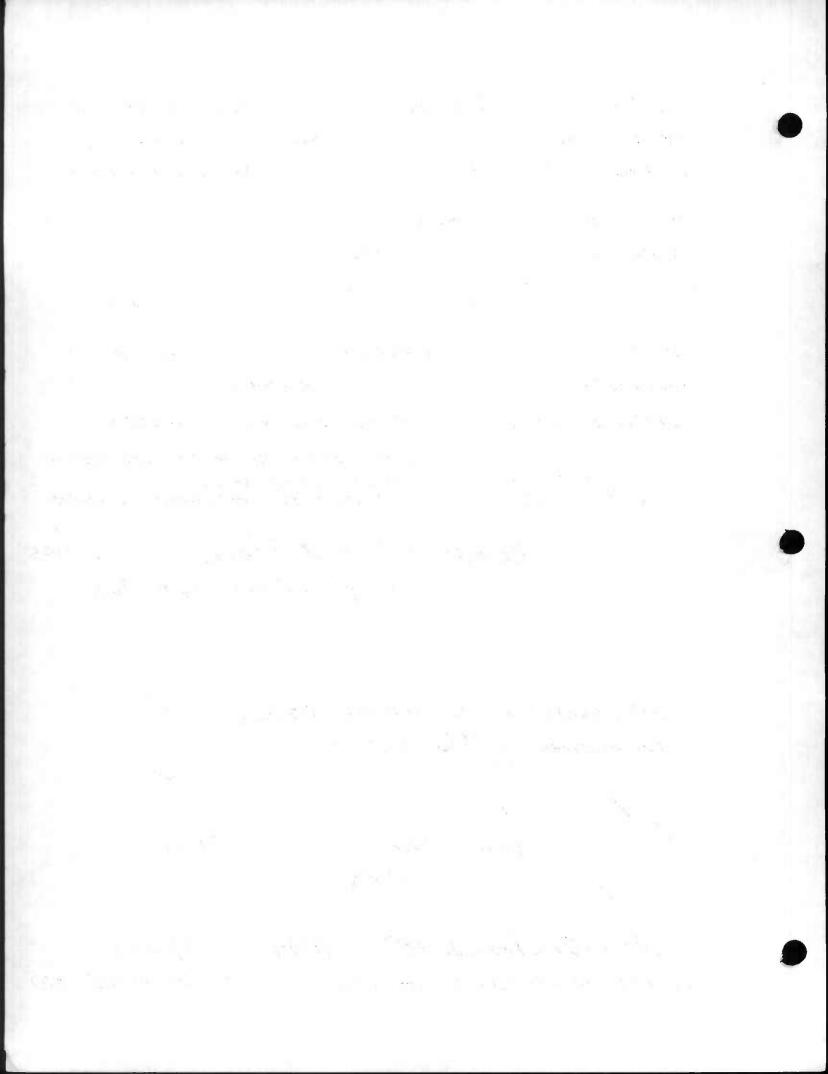
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Examiner	4a Facility Name (If not institution, gir		/111011		4	b. City, To	wn, or Locat	igust ion of Death	4c. County		
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and *	Usual Residence of Decedent  10a. Stata  10b. County		10c. City, Town	or Location						1	0d. Insida City Limits
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d within 72 hours at glene. In then "natural", or in a Medical Exam completed by I	15. Dacadant's E (Spacify only highest gr	ducation	16a. C	ecedent's Usu	al Occup	ation during most	t of working		16b. Kind of B	usinass/In	dustry
s 1 and 2 should be filed within 72 hours of Health and Mentel Hygiene. Item 27 is marked other than "natural", other traumatic event, the Medical Exa To Be Completed by	Elamantary/Secondary (0-12)	Collega (1-4or 5-	+)	Giva kind of wo ifa. DO NOT u homema					dome	etic	
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2 should and Mer is marke raumatic	19a. Informant's Name/Ralationship	(Typa, Print)	19b. I	Mailing Address	s (Street	and Numbe	ar or Aural A	louta Numbe	r, City or Town,	Stata, Zip	Coda)
1 and 2 Health em 27 is	Thomas M Conl	on son					Pool	lesvi	lle, M	D 20	837
poemit. Pages 1 and Department of Health Important: if item 27 any injury or other transcent	20a. Mathod of Disposition  1 ⊠ Burial 2 □ Cramation 3 □  4 □ Donation 5 □ Other (Speci		20b. Place of I cemetary, Monoc		ma of othar plac	ea)	8/1		20c. Location -		
permit. Pages Department of Important: If it any injury or o	21. Signatura of Funaral Sarvica Lica	1411		22. Name at	on	Fune	ral F	Tome			
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ding Physics. After this funeral di	27. Mannar of Daath  1 Natural 5 Panding 2 Accident invastigation	28a. Date of Injur (Month, Day			28c. Injur Wor		280		ow Injury occur		,,
To the Hospital or Attending Physician: The I within 24 hours effect death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicida 6 Could not to datamined	OB Place of lain	ry - At home, farr (Specify)	n, street, factor	ry, office		28f	Location (S City or Tow		ber or Aun	al Routa Number,
n 24 houn n 24 houn ne Funera pietely fille		hysician: To the best o minar: On the basis of and mannar sta	axamination and/								
To the comp	29b. Signatura and titla of cartifiar	youl,	M7.9			e number 2245.	2		29d. Date signa 9UGUST		
	30. Nama and addrass of person who	completed cause of de	nath (Itam 23a) (T	ype, Print) D	327	OC	A NOY.	RAJA	COPAL,	M.D.	TAR AT
State	31. Data filed (Month, Day, Year)		r's Signature					-0	المارون		



State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth 3. Time of Death **Physician** Month IRVIN DAVIS 6:35 am NUG 12 /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Doctors Hospital Lanham Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Feb 28, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Funeral Days Months Hours 1⊠M 2□ F 230-07-5653 Yrs. 76 1922 Director Virginia Usual Residence of Decedent the Marylend 10a. Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 Yes 2 No MD Howard Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 230 19 Pfister Street 20723 USA death v Funeral Items 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian, Bleck, White, etc. 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 7 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò Specify. White 1 ☐ Yes 2 🛛 No Specify. þ 3 Widowed 4 Divorcad 'neturel'. WW II Completed traumatic event, the Medical 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 end 2 should be filed within 7 nent of Health and Mental Hygiene. int. If item 27 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Grade 6 Truck Driver Horse Vans 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Matthew Davis Daisy Burke 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestine Davis /spouse 19 Pfister Street, Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 8/15/98 Fort Lincoln Cemetery 4 Donetion 5 Other (Specify) Brentwood, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert 1. Enter the discrete or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or he mail in a list only one cause on each line. Approximate Intervel Between Onset end Death **Physiclan** Immediate Cause (Final disease or condition resulting in death) /Medical 10 HRS **Examiner** consequence of) Examiner that the deeth certificete be executed buniel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or es e consequenca of) physician the burie Box 68760. Completed by Physician/Medical thet initiated events resulting in death) Lest Due to (or es e consequence of) attending p for use as use as P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed' The law has 1 ☐ Yes 1 □ Yes 2 □ No 2000 of Vital 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 1 Yes 2 ER/Outpetient 3 DOA this 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After Division or Attending s effer de. 1 Natural 5 Pending investigation N/A 1 Yes 2 No 1 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 | Homicide within 24 hours e To the Funeral C completely filled Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner es steted.

2 Medical Exeminer: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one) To the and title of certifier 29b. Signatury 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 6510 KENILWORTH AV. 00 MGACAD MO MO 1 4 1998 State

Registrar



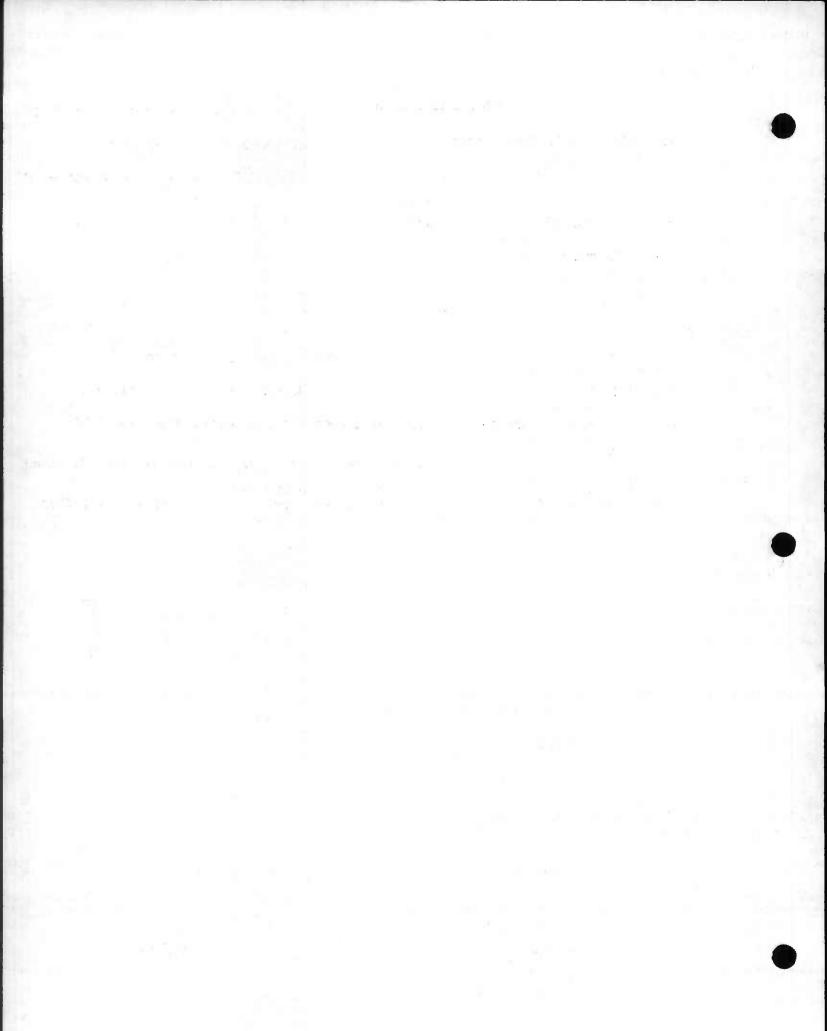
State of Maryland / Department of Health and Mental Hygiene

							-	ificate of	Death		Reg. No.	0 2	0559
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	Exami		4a. Facility Name (If not institu	tion, giva street an	d number)				4b. City, Town, or L	ocation of Daath	4c. Count	y of Death	
			413 W. L	INCOLN AV	/E.				EMMITSBU		FRED	ERICK	
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	anyla sho	-		•								10	od. Inside City Limits  1 ☑ Yes 2 ☐ No
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	igh th	吉	10e. Street and Number					10f. Zip Code			10g. Citizan of	What Count	ry?
	death with the Maryland ms 23a or 28a-f show r mart be northed at		413 W. LINC					2172	·		U. S		
	or de	Funeral	11. Marital Status	Arme	d Forcas?	Evar In U,S.	13. W	as Decedent of as, specify Cu	Hispanic Origin? (Sp ban, Maxican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ca - America ick, Whita, a	
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ζ.	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. It has no see 33 or 28e-f show them 27 is marked other than "nature!", or frams 23a or 28e-f show other traumstic event, the Medical Everticer must be not fled at	Completed	15. Dece (Specify only hig	lent's Education hes <i>t grade</i> com <i>pl</i> e	ted)	16a	(Giva ki	nt's Usual Occu nd of work done	e during most of work	ing	16b. Kind of E	lusiness/Ind	ustry
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	her int.		17. Father's Name (First, Midd	in i act)			2E(	CRETARY	18. Mother's Nem	a /First Middle	GAS CO		
an	ave ave	Be		3. 30.	SDIM							ne/	
Maryland	d Men d Men nerke	10		BERT I. (					SALL				
Na	is n		19a. Informant's Name/Releti						et and Number or Rut				
	m 27		BETTY ANN RED	DING/DAUC	SHTER			SETON tion (Name of	AVE. BOX 3				
0	0 0 - 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramatic	n 3 □Ramoval f	rom State	cemate	ry, crema	tory or other pl		Dete	20c. Location		
E	Pa men ant: lury		4 ☐ Donation 5 ☐ Other	(Specify)		EMM I	TSBU	RG MEMO	RIAL 8/13	3/98	EMMITS	BURG,	MD. 21727
Baltimore,	permit. Pag Department important: I any injury o		21. Signature of Furerai Serv	ce Licansee	.0		22. 1	Name and Add	ress of Facility	KILES F	IINFRAI	HOME	
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de la	Physician		ock, or neer religie. I	ist only one ceuse	OH GOCKI III	Λ —	,	1				1	Onset and Death
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	Examiner		resulting in death)	a	^	Due to (or as a	conseque	ence of:		A	_		
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	oute nd trans	am	Sequentially list conditions,	D		Due to (gras a	conseque	ence of):		X	,		0
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68760,	ificate be executed g physician and as the burial-transit	edicai	Ceuse (Disease or Injury that initiated avents resulting In death) Last	C	0	Dua to (or as a	conseque	nce of):					
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	dea ne att	sici	Part ii. Other significant cond	itions contributing	to death bu	ut not rasulting i	in the und	erlying cause g	ivan in Part I.	23b. Dld 1	obacco usa ce	ontributa to	the cause of death?
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ပ္ထ	s bed	Completed								perio	ineq1	con	npletion of cause leath?
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<u>a</u>	iffical	Be C	25. Was case referred to med	cal					26. Plece of Deat		- /		100 20 10
>	s cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	1 🗆 Inpatie	nt 2 ER/O	utnatient	3□ DOA O	ther	me 5¥7 Resid		her (Snecify	)
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0	offing th.: Afte	atio	1√□ Naturai 5 □ Per 2 □ Accident Inve	ding stigation	Month, Day	r rear)	Injury		ork/ ☐Yes 2☐No				
SIS	Atter r des ector by th	Iffice	3 ☐ Suicida 6 ☐ Cou	id not be 28e. F	lace of inju	ıry - At home, fa	arm, stree	t, factory, office	•	28f. Location (S	Street and Num	ber or Rural	Route Number,
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	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certif	ying Physician: To	the best o	f my knowledge	e, death o	ccurred at the t	time, date and placa,	and due to the	cause(s) and m	anner as sta	ated.
	n 24 n 24 ne Fu	edicai	(Check only one) Madic	ai Examiner; An th	ne basis of manner sta	examination an	nd/or inve	stigation, In my	opinion, death occur	red at tha tima,	data and place.	and due to	the cause(s)
	Within To th	×	29b. Signature and tile of bert	fior /		1 1	11.0	29c. Licar	nsa number		29d. Date sign	ed (Month, E	Day, Year)
			> Ille		1 28	iall	WI >	1	18705		10 4110	ICT 10	100
		10	30. Name and address of pers	on who completed	ceuse of de	eath (Item 23e)	(Type Pr	int)			10 AUG	021 12	170
			ALAN CARROL			S. SETO			ITSBURG, N	ID. 2172	7		
	Sta	te	31. Date filed (Month Aug	7)		r's Signature	, , , , , , ,		210001149 1		,		
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State of Maryland / Department of Health and Mental Hygiene

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uneral irector		5. Social Security 577–30- Usuel Residence	-6240	6. Ser	( )M 2□ F	7. Age (fn yrs 71	. last birthday, Yrs.	Months	Deys	Hours N	lin. (Mc	e of Birth onth, Dey, 19,	Year) 1927		place (State or Fore ntry) nington,
MO W		10e. Stete	10b. Coun	ity		10c. C	ity, Town or L	ocation						1	10d. Inside City Lim
28a-f show	tor	MD	How	ard		Co	lumbia								1 Yes 2□
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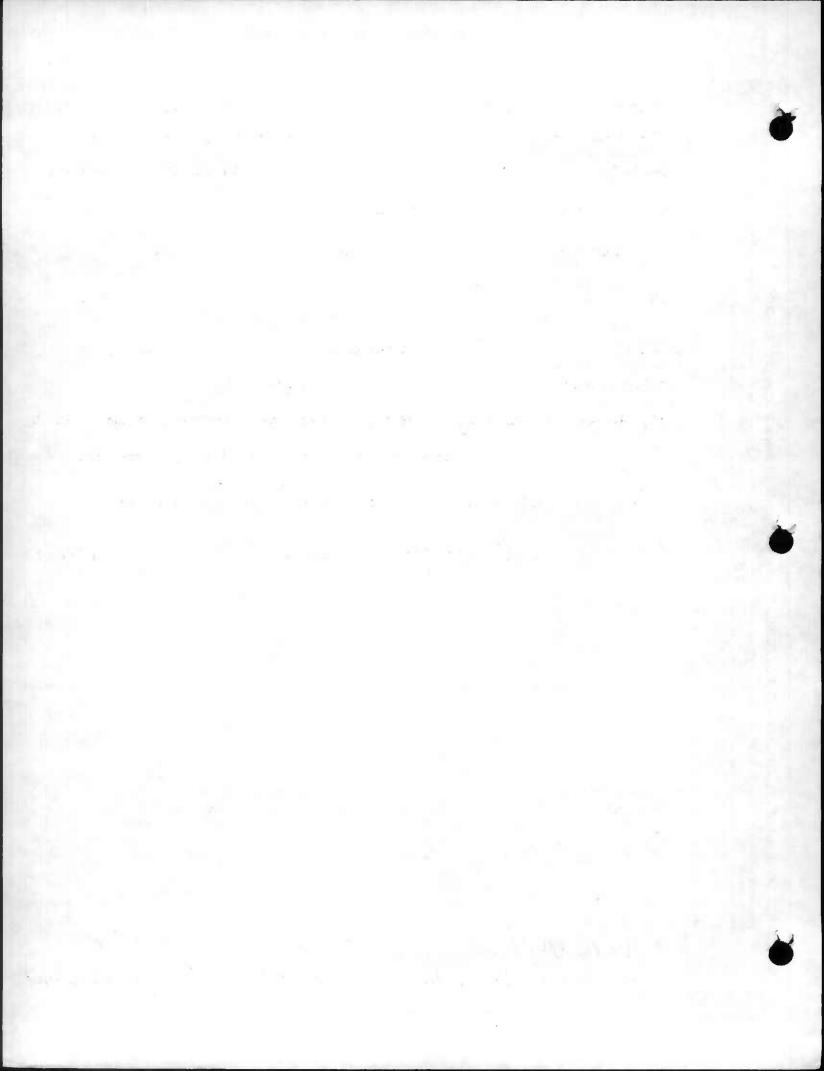
State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician Gambrill** Aug 13 1998 1:00 pm /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7314 Havre Turn Upper Marlboro Prince George If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Yee 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Hours 212-46-7725 85 Director Jan 25, 1913 Maryland Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Prince George Upper Marlboro Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7314 Havre Turn USA Funeral 20772 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter of Hygiene. 1 Yes 2XX0
If Yes, Give
Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2XXX No Specify: Specify: by 3XWidowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 10 Sales woman Dress shop Demit. Pages 1 end 2 should be file.
Department of Health and Mental Hygistopical file of the strength of the marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bradley H. Allen Alice H. Lentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Sally Bledsoe daughter 7314 Havre Turn Upper Marlboro, Maryland 20772 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location · City or Town, State Cedar Hill Cemetery 8/17/98 Suitland, Md. 21. Signature of Funeral Service Limense 22. Name end Address of Facility Donaldson Funeral Home 313 Talbot Ave., Laurel, Md 20707 the mode of dying, such as cerdiac or respiratory arrest, Pert1. Enter the disease, or complications that ceused the deeth. Do not enter shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cholangiocarcinoma year Examiner Due to (or as a consequence of): Examiner law requires that the death certificate be executed physicien and strans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): SB attending p for use as signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? been si 24a. Was an autopsy performed? Completed his certificate hes b The 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No death Director: A 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours after To the Funeral Direc completely filled in bi after 4 Homicide Hospital edical 29a. Certifier Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Lacen 5 30. Name and address of person who completed hause of death (Item 23a) (Type, Print) onse Hory etars Michael N.

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 0 1998

32. Degistrar's Signature



State of Manyland / Department of Health and Mental Hygiene

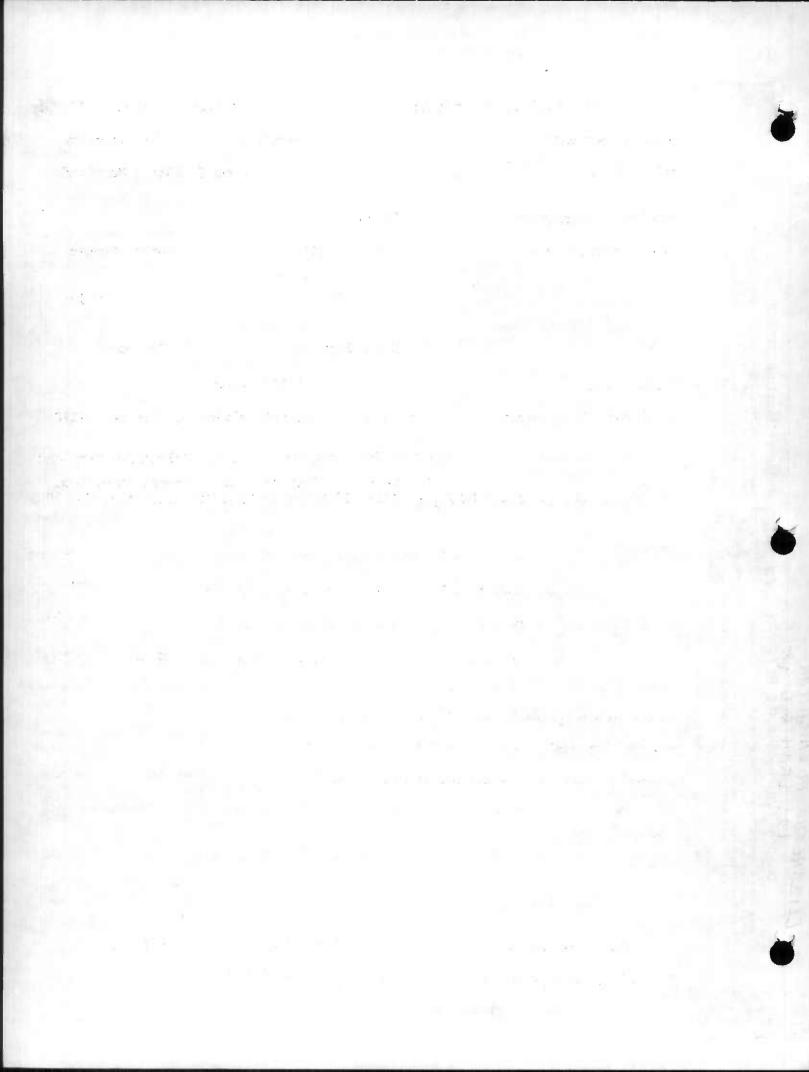
ended #13	State of Maryland / Department of Health and , 8/28/98, CWC, Kent Co. <i>Certificate of Death</i>		Reg. No.	26562
Physician	1. Decedent's Name (First, Middla, Last)	2. Date of De Month	Day	3. Tima of Death
/Medical	RICHARD HEMSLEY III  4a. Facility Name (If not Institution, give street and number)  4b. City, Town, o	AUGUS		1998 0115
Examiner			KEN	
Funeral	KENT & QUEEN ANNE 'S HOSPITAL, INC. CHESTE  5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Months Days Hours Mit	S. 8. Data of Bit	th Veer	9. Birthplaca (Stata or Foraign Country)
irector	219-05-8531 78 Yrs.	January	17, 1920	Maryland
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Insida City Limits
lo lo	Maryland Kent Chestertown			1X Yes 2 □ No
frer must be notified Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizan of V	Vhat Country?
alD	7890 Whitworth Court 21620		U.S.A.	
Iner	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Maxicen, Pua	Specify Yes or No		e - American Indian, ik, White, atc.
by Fu	1 □ Never Married 2 🖾 Married 1 ◯ XYes 2 □ No   If Yas, Give 1 □ XYes 2 □ No   If Yas, Give 1 □ XYes 2 □ No   Specify: Yaar or Deles: 1943–1972	,	100	White
8	15. Decedent's Education 18a. Decedent's Usual Occupation		16b. Kind of Bu	siness/industry
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E	12 10 Colonal		United St	ates Air Force
Be Completed		eme (First, Middle		Θ)
5		Seth Wo		
traum	19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Addrass (Street and Number or F   Winifred Edwards Hemsley/Wife   7890 Whitworth Court,			
ther	20a. Method of Disposition 20b. Place of Disposition (Nama of	Date		City or Town, Stata
any injury or other traumatic syant, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State cemetery, cramatory or other place)	I .		
Inju	4 Donation 5 Other (Specify) St. Pauls Cemetery August 2  21 Signature of Funeral Service Licensee 22. Name and Address of Facility	41, 1990	Chesterto	wn, Maryland
any Ir	Fellows, Helfenbein & I			
	23a. Part Finar the disease or complications that caused the death. Do not enter the mode of dying, such as cardinated when the mode of dying, such as cardinated when the mode of dying are the shock, or heart failure. List only one can use on each line.	ac or raspiratory a	y Land 2162 rrest,	Approximata
cian	Stock, of real tailure. List only one muse on each line.			Interval Between Onsat and Death
dical niner	Immediate Cause (Final disease or condition resulting in death)  a. Appration & Pheumonit	i <		<5hrs.
	Due to (or as a consequence of):			
the buriel-transit	Lipopratosis			
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying			
dical	that initiated events  C			
0 2	resulting in death) Last			
Physician/M	d			
ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Díd	tobacco use cor	ntribute to the cause of death?
표	ASCV Ds; Spleenomegaly; CHF; Afib;	Ú.	Yes 2□ No	3 Probably 4 Unknown
d by	ADD: HTD: W PUD TO LONG. N	_// 24a. Was	an autopsy	24b. Wara autopsy findings
page 2 should be detached for usa	COPD; HTW; KxPUDz; Trunkal Afaxia, Myo		ormed?	avaliable prior to completion of cause of death?
age 2	gout; Arthritis; Angiodysplasm & Colon; KipRepl	out in	Yes 2□No	1.MYas 2□ No
director, page	25. Was case referred to medical 26 Place of D	eath (Check only		199 100 2010
ral director, pag.	examiner?  1  Yas 2 No	Homa 5□ Res	dence 6 Oth	ar (Specify)
funeral flon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Unjury at Work?  28a. Date of Injury 28b. Time of Unjury at Work?	28d. Describe	how injury occurr	ed
the th	2 Accident investigation M 1 Yes 2 No	004 1	·	0.10.1.
completely filled in by the funera	determined  determined  determined  determined  determined  determined  determined  determined  determined  determined  determined  building, etc. (Specify)	City or To	Street and Numb wn, State)	er or Rural Route Number,
D E	29a. Certifier 1 № Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.	ce and due to the	ceuse(s) and ma	nner as stated
completely filled in by the Medical Certifical	(Check only one)  2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurrence and manner stated.	curred at the tima,	date and place, a	and dua to tha causa(s)
	29b. Signature and title of certifier 29c. Licansa number		200	i (Month, Day, Year)
18	D50996		8/18/	98.
1	30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)		,	
1	Neil Stoddard 100 Brown Street Chester	town, 1.	nd. 21	1620
State	31. Date filed (Month, Day, Year)  32. Registrer's Signature			

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State of Maryland / Department of Health and Mental H	ygiene (	C
Cartificate of Death	0	-

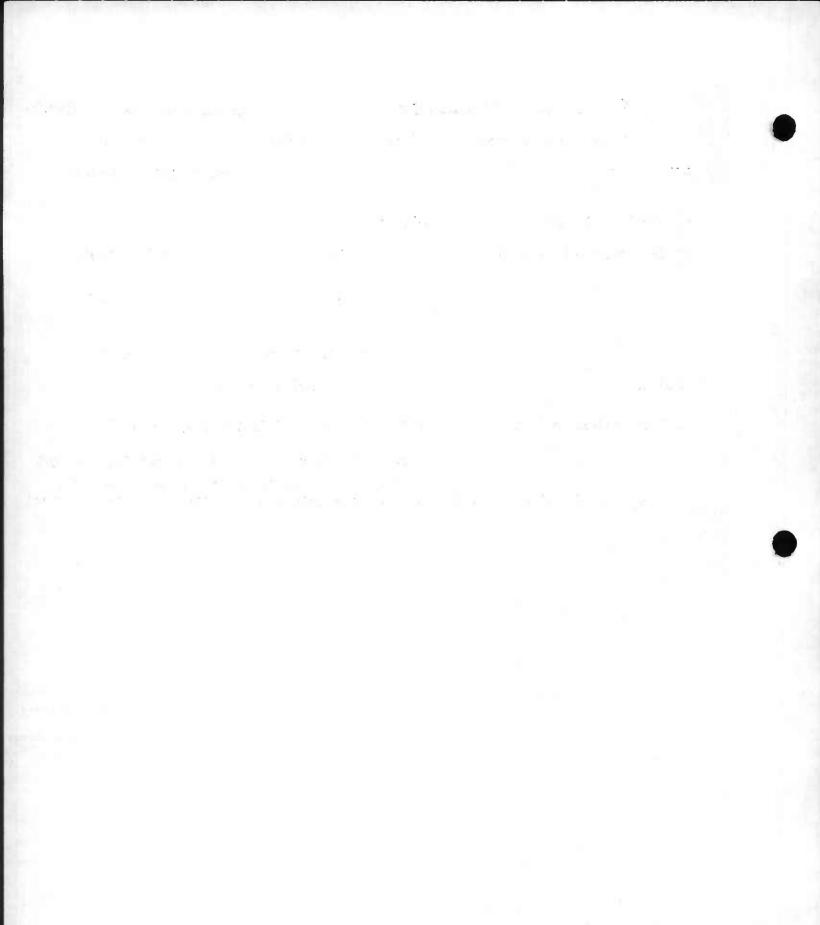
			State	of Marylan		artment of H			giene 9	2	6563
	1100	1. Decedent's Neme (First, Middle, La	st)	1000				2. Dete of De Month	eth Day	Year	3. Time of Death
	Physician /Medical	Elizabe	eth B.	Huebschn	nan			August		998	12:25am
	Examiner	4e Fecility Neme (If not institution, giv		umber)		4	lb. City, Town, or	Location of Deeth	4c. County	of Deeth	
		Suburban Hospital				Milladay 1 Vany	Bethes			ntgo	
	Funeral	5. Social Security Number 6. S	ex □M 2DXF	7. Age (In yrs.	lest birthday) Yrs.	Months Deys	If Under 24 Hrs Hours Min.	. (Month, De			pleca (Stete or Foreign ntry)
- 10	Director	214-16-6450 Usuel Residence of Decedent		84				June 6	, 1914	Mar	yland
	show	10a. State 10b. County		10c. City	y, Town or Lo	ocation					10d. Inside City Limits
	r 28a-f show Inciting at	Maryland Montgo	mery		Bethe	esda					1 ☐ Yes 2 ☑ No
	vith the Mer or 28a-f s be notified Director	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cou	ntry?
		5550 Tuckerman La	ne			20	817		Unite		
		11. Marital Status	12. Wes De Armed F	cedent Ever in U, forces?	S. 13.	Was Decedent of H If Yes, specify Cube	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Red Ble	e - Ameri ck, White,	can Indian, etc.
20	9 0 3	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G Year or	Forces? 2 No		1 ☐ Yes 2 ☒ No	Specify:		Specif	y: 1	White
Ş		15. Decedent's Ed		Deles.	16e, Dece	dent's Usuel Occup	etion		16b. Kind of B		
15	n n ne	(Specify only highest green Elementary/Secondary (0-12)	de completed	(1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wo	nrking			
213	filed within 72 ho Hygiene. ther than "nature out, me wedgal.	Elemanary (0-12)	College	(1-401 5+)	Ho	memaker			Own	Home	
P	= + 5 5	17. Fether's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumer	ne)	
yla	should be nd Mental marked o umatic ev	Vaughn Legar					Lilly	Jacobs			
a	ith and Mental Hith and Mental Hit is marked of traumatic even	19e. Informent's Neme/Reletionship (				ng Address (Street					
0		H. Richard Piet/S	tepson		1	Vest 25th	Street				
altimore, Maryland 21215-0020	Pages 1 el lent of Hea nt: if item iny or othe	20a. Method of Disposition  1XX Burial 2 Cremetion 3	Removel from	n State C	emetery, crei	metory or other place		Dete	20c. Location		
tim	t. Pa tmen tant: sjury	4 Donetion 5 Other (Specif		New		edral Cem		8-8-98	Baltimo	re, l	Maryland
Bal	permit. Pages Depertment of important: if it any injury or o	21. Signature of Funerel Service Licar	nsee	( ~ 1	∫ Ha	2. Name and Addre	itzke's	Family F	Tuneral	Home	, Inc.
		Dem a. C	olline	5- Why	141	l12 old C	olumbia	Pike Ell	licott C	ity,	MD 21043
		23a. Part1. Enter the disease, or com shock, or heart feilure. List only	one cause on	eech line.	n. Do not en	er the mode of dyin	ig, such es cardia	ic or respiretory e	errest,		Approximate Intervel Between Onset end Deeth
	Physician /Medical	Immediete Ceuse (Finel	1	150							
	Examiner	diseese or condition resulting in death)	e. Cav	ner of	r es a consec		mary			<u> </u>	unknow
	i i		0/00	eminal !			· · ·	to			unterens
	executed in end iel-transit	Sequentially list conditions.	b. a pou		r es e consec	,	5	10 00 1			
0,		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Bou	el nor l	are t	win de	ue to	a . h		i	36 hrs
8760,	ate be explored the burie	that initieted events resulting in death) Lest	С.		r as e consec	101		0-1-3		1	
900	ling p		1 acu	uta Go	28 moni	toghnal	heracore	igh due	to # c		36 hrs
AN Box	The law requires that the death certificate be set has been signed by the ettending physicic, page 2 should be detached for use as the bu Completed by Physician/Medical		0					0			
500	the de ched	Pert II. Other significant conditions of	ontributing to	death but not resi	ulting in the u	nderlying cause giv	en in Pert I.				to the cause of death?
I do	thet the the detail detail detail detail v. Ph	bilateral malign	untn	lound of	ause	is with	5	. 10	Yes 2 No	3[] Pro	obably 4 Unknown
M. M. ords	law requires that the as been signed by the 2 should be detached prieted by Physical			,	, -			24a. Wes	en eutopsy	24b. W	Vere eutopsy findings
E B H	been shou	respiratory dist	ress 1	severe "	returo	lic acide	escs,	perf	omed?	C	veileble prior to ompletion of cause f deeth?
Ren	certificate has rector, page 2		. T	0101	4 1			10	Yes 2000	1	☐ Yes 2☐ No
I Sel	entificet actor, p	5 yudane of in appro 25. Wes case referred to medical	mwa	antiqua	retich	ormena	26. Place of De	eeth (Check only			
	nysician: nis certific il director, To Be (	exeminer? 1 Yes 2 No	Hospitat:	Inpatient 2	ER/Outpetier	nt 3 DOA Oth	00	Home 5□ Res		ner (Spec	ify)
7 30	E 5 2	27. Manner of Death	28e. Det	e of Injury enth, Dey Year)	28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe	how Injury occu	rred	
ABET	tal or Attending Ph rs after death. al Director: After th led in by the funerei Certification:	1 Neturel 5 Pending investigation	n	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2 □ No				
N is	atter deal Director: J in by the	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Plac	ce of Injury - At ho ding, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location ( City or To	(Street end Num wn, State)	ber or Rui	ral Route Number,
A D	Ital or rai Dirtied in										
ELIZABÉ Divisio	To the Hospital or At within 24 hours atter of To the Funaral Direc completely filled in by Medical Certifi	(Check only 2 Medical Exam	ninar: On the	basis of examina		h occurred et the tin vestigetion, in my o					
EL	thin 2 the mplet	29b. Signeture end title of certifier	end ma	nner stated.		29c. Licens			29d. Date sign		
	N N N N N N N N N N N N N N N N N N N	The second secon					31282				-5, . 50.
	10	albert & L							8/6		
	10	30. Name end eddress of person who 5 uburban Hos.	completed car	Sho O	23e) (Type,	Georget	own R	d Both	esda n	2	20814
	State	31. Dete filed (Month, Day, Year)	32.	Degistrer's Signe	eture	J					
4 1000	Registrar	AUG 1 0 1998	3 9	egistrer's Signe	on-Rand	all					

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State of Maryland / Department of Health and Mental Hygiene

hysician		4. December 11 to 12 to	- 4		Cen	ificate (	of Death		Reg. No.		
	1	Decedant's Nama (First, Middla, La	, ,,		8-	,		2. Data of Date Month	ath Day	Yaar	3. Tima of Death
/Medical		KuTH.		4	w BEC	1		Oceje		798	12:10 Am
Examiner	r	4a. Facility Nama (If not institution, giv		7 **				Location of Beath			
		Howard Cou			-		Columb			ward	
uneral rector	-	000-10-4401	DA OFT	a (In yrs. le 87	est birthday) Yrs.	if Under 1 Ya Months Da	aar if Undar 24 Hr lys Hours Mir		y, Year) 15,1911	9. Birthplac Country New	ca (Stata or Foraign York
2	-	Usual Rasidance of Decedant  10a. Stata 10b. County		100 City	, Town or Loca	ation				101	
sho n		22.47.9								100	l inside City Limits 1 ☐ Yas 2 No
Pearl of of	2	Maryland Howard	l		Columb:	ia					TE TAS ZOINO
at be n		10e. Street and Number 10799 Hickory Ridg	je #236			10f. Zip Coo	044		10g. Citizan of V Unit	What Country	
ral', or items 23a or 28a-f show Examiner, must be notified at I by Funeral Director	Dy ruiler	11. Marital Status  1 □ Nevar Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas? 1  Yas 2 If Yas, Giva Yaar or Datas:	Evar in U,S No			of Hispanic Origin? ( Cuban, Maxican, Pua No Specify:	Specify Yas or No- rto Ricen, atc.)	14. Rac Blac Specify	e - Amaricen ok, Whita, ato whita	o
r, the Medical E		15. Decedant's Ed	Jucetion		16a. Deceda	nt's Usuai Oc	cupation	I Delicario	16b. Kind of Bu	usiness/Indus	stry
n n	2	(Specify only highast gra			(Giva ki lifa. Do	ind of work do O NOT usa re	cupation ona during most of we tired)	orking			•
is marked other than "natural", sumatic event, the Medical Exa	5	Elamantary/Secondary (0-12)	College (1-4or :	0+)			red Nurse		Healt	hcare	
e He		17. Fathar's Nama (First, Middla, Last)						ama (First, Middla,			
Be		Fred A. Lamb					Nellie				
or other traumatic event, the Medical	-	19e. Informant's Name/Ralationship (	Type Print)		19h Mailing	Address (St	reet and Number or F		City or Tour	State Zin C	oda)
9 8	1		***								oue)
any injury or other tr	- 1	R. Gary Hollenbeck 20a. Mathod of Disposition	Son	20h Pia	34UL S	Sylvan	Lane Elli	Data C1t	Y, MD 2 20c. Location		Ctoto
0		1 Duniai 2 ☐ Cramation 3 D	Ramoval from Stata		ace of Disposi matary, crame						
jury	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Sto			etery	8-14-98	Munnsvi	lle, N	New York
dician dical miner		23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only Immediata Causa (Final disaasa or condition rasulting in daath)			Do not antar	112 OLo	drass of Facility Witzke's Columbia dying, such as cerdia	a Pike El ac or raspiratory ar	licott	City,	MD 21043 pproximata tierval Between insat and Death
<b>a</b>	5		0	Dua to (or	as a consequ	ance of):	//	. /		1	
Examiner			b				ant for	lone		7~	ears
xa xa		Sequentially list conditions, if any, leeding to immadiata ceuse. Entar Undartying Cause (Diseesa or Injury		Dua (or	as a conseque	ence of):				4	
bund a	5	Cause (Diseesa or Injury	c							i	
es the bunel-transit	3	that initiated events rasulting in daath) Last		Dua to (or	as a consaqua	ance of):				į	
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for use		_	0.								
ysic	5	Part II. Other significant conditions of	ontributing to death b	ut not rasui	ting in tha und	darlying couse	givan in Part I.	23b. Did 1	obacco uae cor	ntribute to th	ne cause of death?
be detached for use by Physician/								10	Yes 20 No	3 Probat	bly 4 ☐ Unknow
2 should									an autopsy med?	avaiis	autopsy findings abia prior to plation of ceuse ath?
Бод								101	as MNo	1 🗆 Y	fas 2□ No
0 0		25. Was casa rafarred to medicel					28 Place of De	eth (Check only o		1	
0		axaminar?	Hospital:	nt 2 🗆 🗆	R/Outpatient	3□ DOA	Other	Homa 5 ☐ Rasio		ar (Canaihi)	
		27. Mannar of Death	28a. Data of Inju	ry :	28b. Tima of				now injury occurr		
funer		1 Naturel 5 Panding invastigation	(Month, Da	Year)	Injury		njuryat Work? 1 □ Yas 2 □ No				
Certification:		2		ury - At hon c. (Specify)	ne, ferm, strea			28f. Location (\$ City or Tox	Streat and Numb m, State)	er or Rural R	Routa Number,
9 0		(Check only 2   Medical Exam	ysician: To the best of	axamination	ledge, daath o	occurred at the	a tima, data end plac ny opinion, daath occ	e, and dua to tha curred at tha tima,	causa(s) and me data and place, o	enner as state	ed. na ceuse(s)
fely fil		one)	and mannar sta	ited.							
mpletely fil		20h Sinnature and title of courties				29C. LIC	ensa number		29d. Data signed	a (Month, Da	y, rear)
completely fil		29b. Signature and title of certifier				_		-30	//	11	0-1
completely fi		29b. Signature and title of contiller	-			1	22856		August	11,19	38
completely fi		· De	complated ceusa of d	eath (Itam :	23a) (Type, Pr	rint)	22856	1	August	11,19	98
To the Funeral Dire completely filled in b Medical Certi		29b. Signature and talle of cartifler  30. Name and address of Serson who	complated ceusa of d	eath (Itam :	23a) (Type, Pr	rint)	22850	and Aken	Colem	11,19.	98 nd 2107



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** 1998 20:26 Elizabeth Joan Hippen Avqust /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner of Baltimore City Maryland Hospital None If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 X F 577-48-8006 Director 61 Apr 5, 1937 Washington DC Usual Residence of Deceden the Marylend 10a State 10b Count 10c. City, Town or Location 10d. inside City Limits Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen ent of Health end Mentel Hygiene.
Int: If Item 27 is marked other than "natural", or items 23s or 28s-f show my or other than the world. The Medical Estring must be notified any or other traumatic event, the Medical Estring. 1 Yes 2 No Director Maryland Howard Glenwood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14586 MacClintock Drive 21738 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2₺ No Specify: 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Hame 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Mullikin Sara E. White 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorin E. Hippen/Husband 14586 MacClintock Drive Glenwood, Maryland 21738 permit. Pages 1 end Department of Healt Important: If Item 27 eny injury or other QDCs. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Columbia Memorial Park 8-17-98 Clarksville, MD 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licenses Den a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physiclan** /Medical Immediate Cause (Final Aspergillosis disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner Due to (or as a consequence of): The lew requires that the death certificate be executed physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Division of Vital Records, P.O. Box 68760, Bone Marrow ronsplan Physician/Medical Due to (or es e consequence of): as ettending for use as Multiple Myeloma signed by the e 23b. Did tobecco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings evellable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? iis certificate has b director, pega 2 s 1 Yes 2 □ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director; g 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Npatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Neturel 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end manner es steted.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Physician 1998 P10209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Singer MD 21201 Greene St. Bultmore. South Daniel

32. Registrar's Signature
Sylia Davidson-Randelle

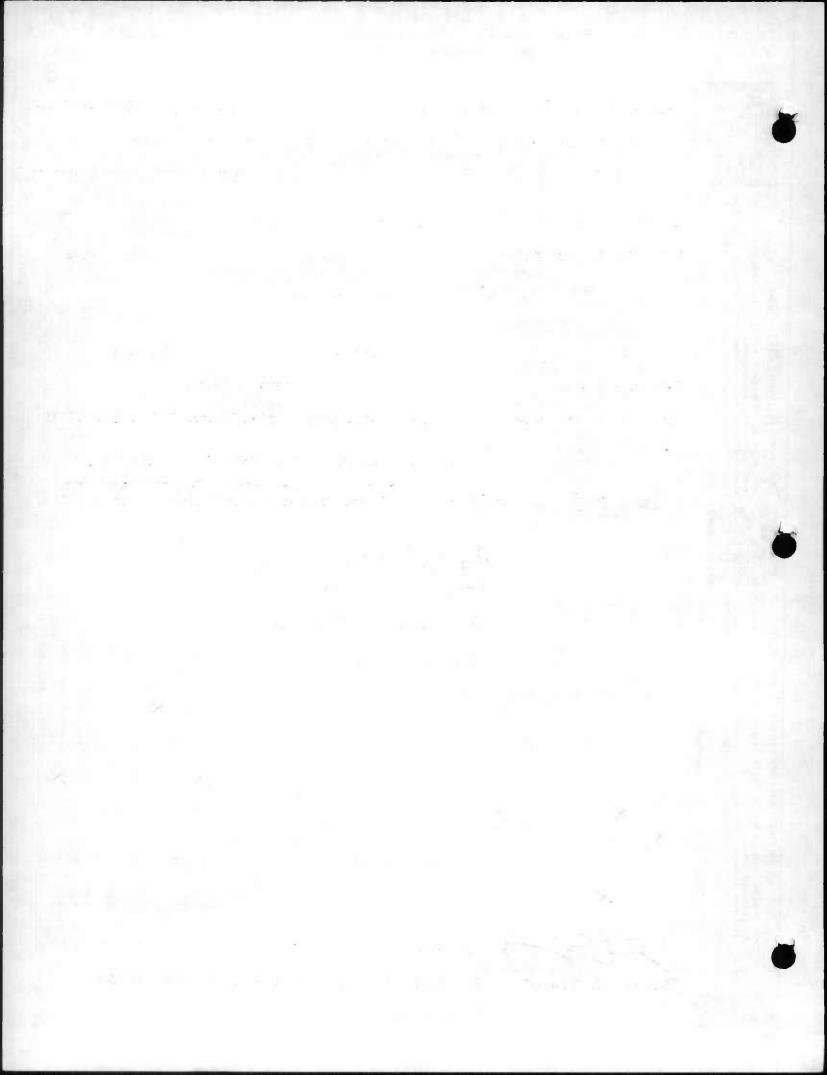
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

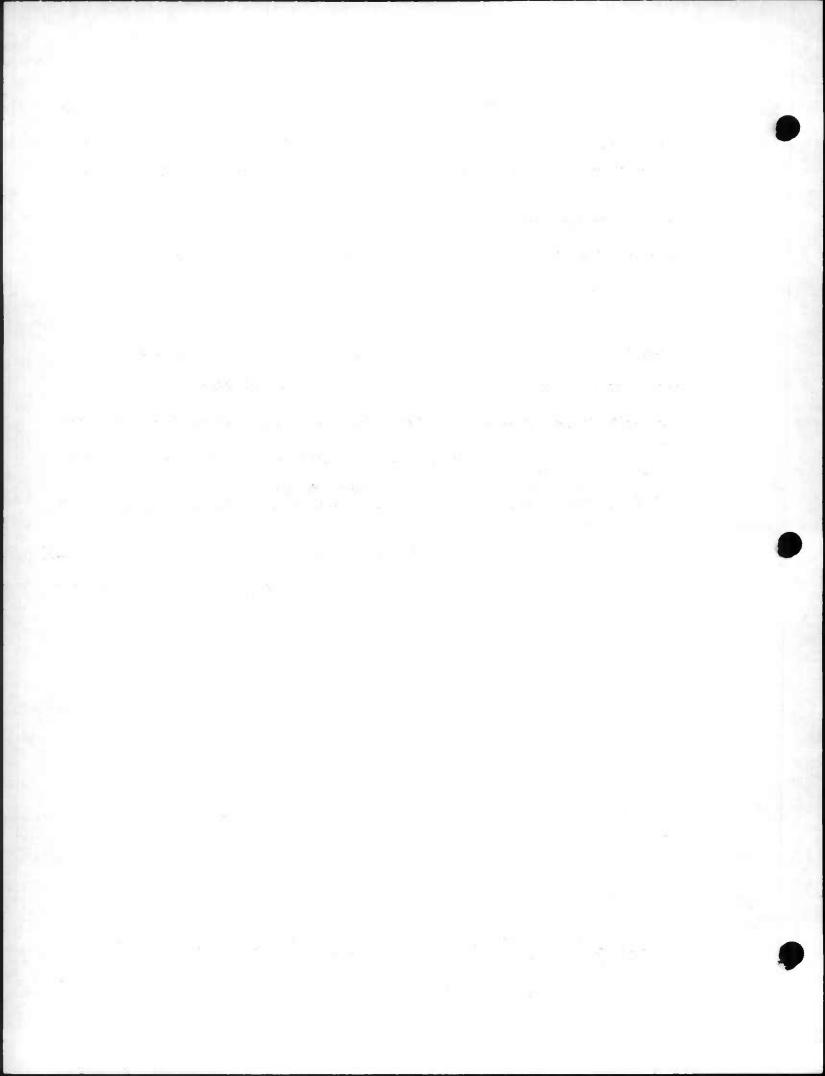
AUG 1 4 1998



State of Maryland / Department of Health and Mental Hygiene 🛚 🦳

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Deeth **Physician** Pay 11, 1998 Helen Albertha Hanus August 11:30 am /Medicai 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 12910 Northpoint Lane Laurel Prince George If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month Day, Jul 16, 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Funerai 1□M 2XF Maryland 219-76-3018 87 Director Yrs. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner naut be notified at Director 1 ☐ Yes 2 XNo Prince George Laurel 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12910 Northpoint Lane Items 23a 20708 USA Funeral death 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed th end Mental Hygiene.
7 is marked other than "natur treumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Home maker Own home 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If item 27 is marked othe any liqury or other treumatic event sone. 18. Mother's Name (First, Middle, Meiden Sumeme) Be Sylvester Whitehead Agnes Robinson 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Charles M. Hanus /spouse 12910 Northpoint Lane, Laurel, Maryland 20708 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete Meadowridge Memorial Pk 8/14/98 Dorsey, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funerel Ser Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23e. Part1. Enter the constant or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart a une but only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Hemorrhage /Medical Immediate Cause (Finel Months Cerebral disease or condition resulting in death) Examiner erebnovascular Accident Physician/Medical Examiner The law requires that the death certificate be executed buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of) Box 68760. the Due to (or as e consequence of): ò P.O. Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Allnknown Records, þ 9 pege 2 should 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? certificate 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this the funeral 27. Manner of Deeth Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1. Naturet s efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) in by t 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 ☐ Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner es steted.
2 ☐ Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the the 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 12,1998 43260 eddress of person who completed cause of deeth (Item 23e) (Type, Print) 30. Neme end Baltimore Avenue Caurel Maryland 20107 31. Date filed (Month, Day, 32. Register's Signature Year) State 1 4 1998

Registrar



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) **Physician** Shirley JeNell Halsey tuckst 0 \* /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne mil ode If Under 24 Hrs Birthplaca (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5 Social Sacurity Numbar **Funeral** 1□M 2X F Months Days Hours 75 Director Jan 8, 1923 215-12-3142 Maryland Usual Residence of Deceden the Maryland 10e State 10h County 10c. City. Town or Location 10d. inside City Limits pormit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any Injury or other traumatic event, it's Malical Examine. 1♥ Yes 2□No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1463 Berger Street 21113 IISA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 N Widowad 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Administrative Assistant U.S. Government 18. Mother's Name (First, Middla, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Be George P. Dawson Myrtle Payne 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Intorment's Neme/Relationship (Type, Print) Melvin D. Saunders /son 1463 Berger Street, Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/14/98 Catonsville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the diffusion complications that ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart a unit built only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final 1 das Cardio respirate disaasa or condition rasulting in daath) Examiner Due to (or as a consequance of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760 certificata be Physician/Medical Due to (or as a consequence of): 88 attending usa Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by t Dements p 24b. Were autopsy tindings available prior to completion of ceuse of death? 24a. Was an autopsy Completed peen 2 No 1 □Yes 2 □ No 1 TYes certificata Division of Vital funeral director, 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ot 28c. injury at Work? 28d. Describe how injury occurred Certification: Aftar 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accidant To the Hospital or Attend within 24 hours after death To the Funeral Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title ot certifier 29c. License number 023(24)

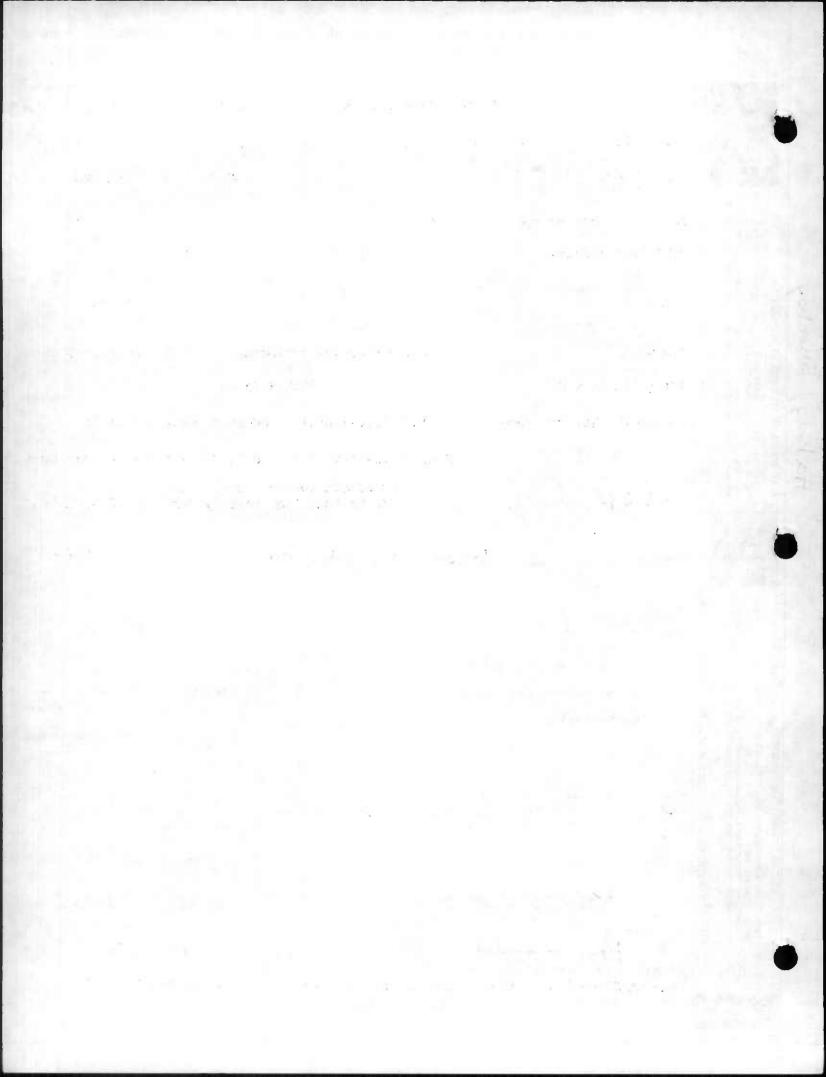
1600 Crain Highway, SW Suite 201, Glen Burnie, MD 21061

State Registrar 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

32. Registrates Signature

Basant Khandelwal

Shirley



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth **Physician** AU6 Roy B. Harris /Medical 4a. Fecility Nama (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore St. Aynes Hospita None If Undar 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yaer 5. Sociel Security Number 7. Aga (In yrs. lest birthdey) Birthpleca (State or Foreign Country) Funeral Deys 1⊠M 2□ F Yrs. Director 404-05-0064 81 July 8, 1917 Kentucky Usual Residence of Dacedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinur must be notified at 1 Yes 2X No Directo Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? death with 2007 Halethorpe Avenue 21227 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Wes Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puarto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours efter to Department of Healith and Mental Hygiene. Important: if item 27 is merked other than "natural", or ite any injury or other traumatic event, the Mental Examina 1 X Yes 2 No
If Yes, Give
Yeer or Dates: 1943-45 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify by 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrical 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Surnama) Floyd Harris ဂ္ Maggie Brooks 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Sharon J. Kidd/Daughter 2007 Halethorpe Avenue Baltimore, Maryland 21227 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Md Nat'l Memorial Park 8-15-98 Laurel, Maryland 22. Nome and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signeture of Funeral Service Licenses 5 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disaase, or complications that causad the feeth. Do not antar tha mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final · Subarachnoid Hemorrhage disaesa or condition resulting in deeth) Examiner Protime (Coagulopathy) Supratherapentic ettending physician and for use es the burial-transit Sequentially llst conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest Box 68760, Physician/Medical Dua to (or es a consequança of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown Hypertension, Coronwy by 24a. Was an autopsy performed? 24b. Were eutopsy findings evelleble prior to completion of causa of deeth? Disease, Chronic Renal Diverticular Disense 2 1 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical exeminer?
1 ☐ Yes 2 ☐ No Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of After this in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Pending Investigation 1 Neturel deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Numbar or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, data and place, and due to the ceuse(s) and menner stated. 29a, Certifier 29b. Signetura end title of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year) Medical Resident 0 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 900 cator Ave Baltimore md, 21229 mo Shannon State

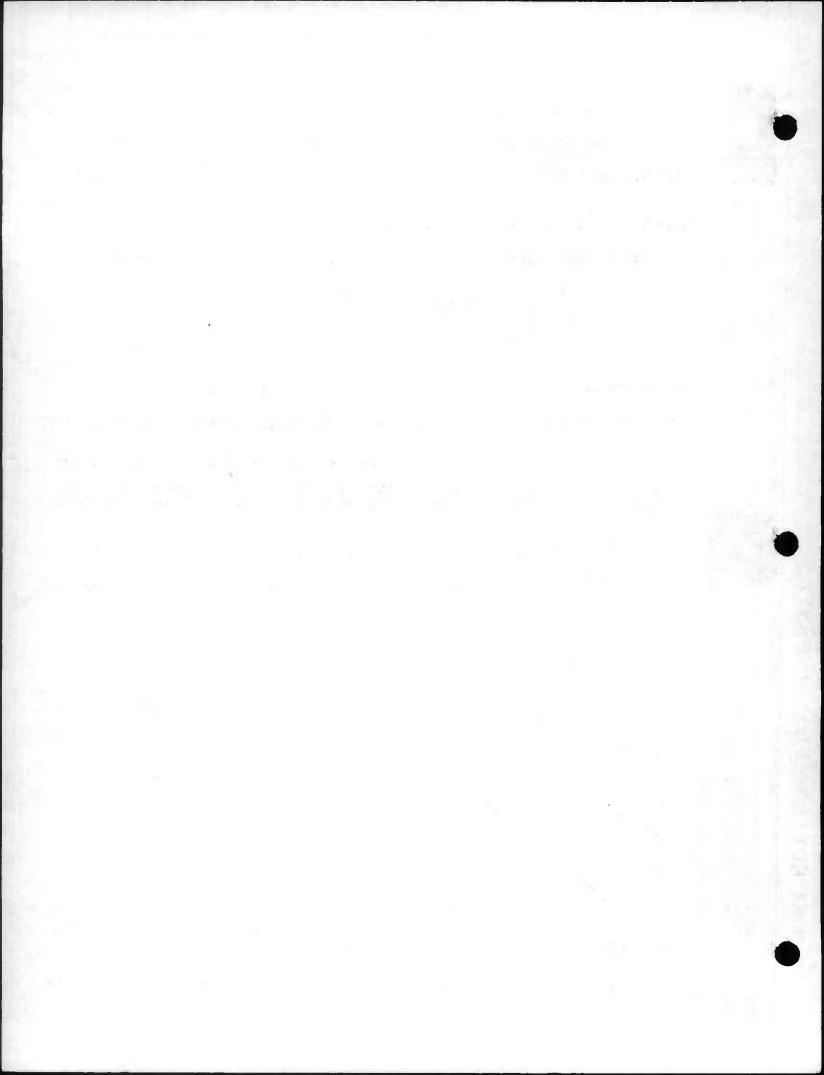
DHMH 16 Rev 6/95

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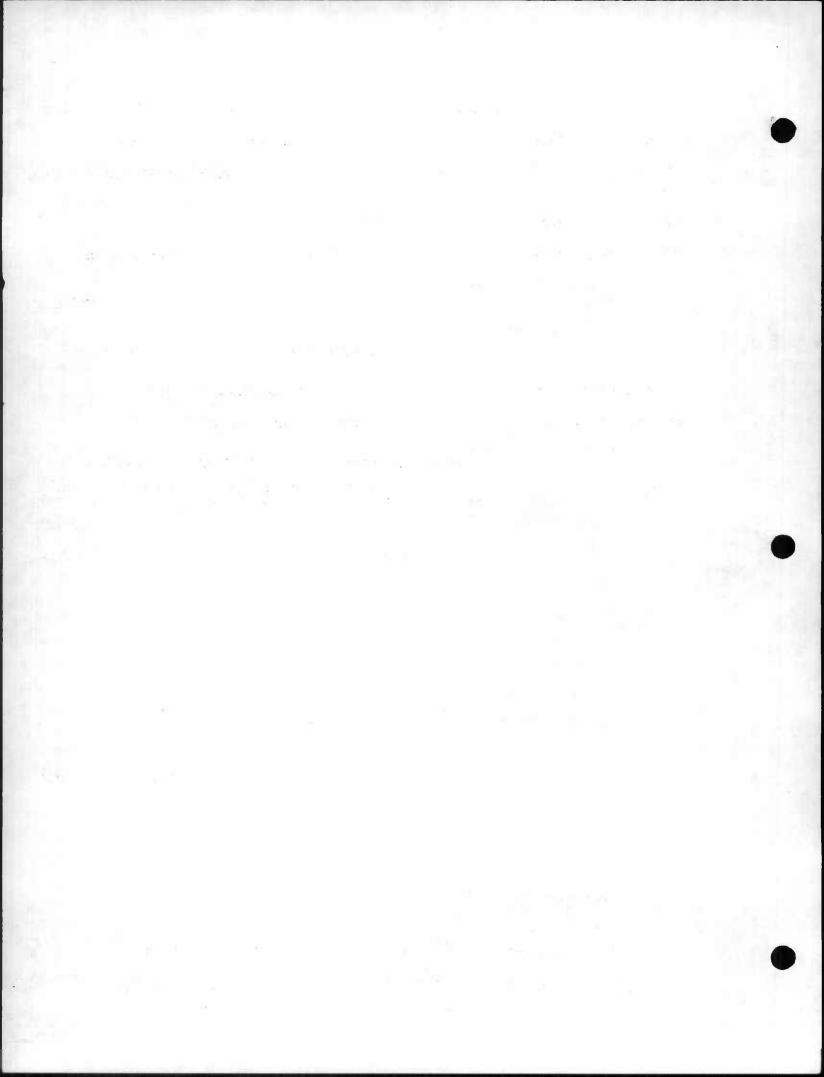
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** James B. Hedrick Jr. 1998 August 15 9:50am /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Lorien Nursing Home Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours Min 12 M 2□ F Yrs. 577-10-7309 89 Director March 8,1909 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examines must be notified at 1 ☐ Yes 2 No Directo Maryland Howard Clarksville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6105 Thompson Drive 21029 United States death Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ (∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Status Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mentel thygiene. ant: if Item 27 is marked other than "natural", or ite nry or other traumatic event, the Magical Eagle. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter/Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James B. Hedrick Sr. 0 Bessie Ellen Harouff 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Young/Daughter 7809 McIver Road Laurel, Maryland 20723 altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of important: if any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 8-17-98 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Harry H. Witzke's Family Funeral Home, Inc. Su me a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): use as ettending o signed by the a Part II. Other algnificant conditions contributing to deeth but 1pt resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? Completed 24a. Wes an autopsy peen page 2 certificate 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was cese referred to medical Be 26. Place of Death (Check only one) Other: Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Matural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Critifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) Date signed (Month, Day, Year) 29b. Signeture and title of cerum 29c. License number D 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Plucy Colom State 1998 Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 3. Time of Death 2. Dafe of Deeth **Physician** LATARSHA CHRISSE HOLT 9:00 PM August /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE Hours Min. 8. Data of Birth NOV 01, 1972 7. Aga (In yrs. last birthdey) If Undar 1 Year Birthplace (Stata or Foraign Country)
 MD 5. Social Security Number **Funeral** Months Deys 1□ M 25 F 25 213-78-6766 Yrs. Director Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City. Town or Location 10d, Insida City Limits MD. BALTIMORE Yas 2 No Director NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23e or 1024 TUNBRIDGE RD. 21212 U.S.A. Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Yaar or Datas: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1X Never Married 2 Married Specify: BLACK 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur treumstic event, the Medical 16a. Decedant's Usual Occupation
(Give kind of work dona during most of working
lifa. DO NOT user artired)
DIASBLED 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) NA 12 TH. 18. Mofhar's Nama (First, Middle, Maidan Sumame) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be file mant of Health and Mental Hy ant; if Item 27 is marked oth iury or other treumatic event Be EARL W. HOLT ETHEL MAE DAVIDSON 19a. informant's Name/Ratationship (Type, Print)
ETHEL MAE DAVIDSON 19b. Mailing Addrass (Straat and Number or Rurel Route Number, City or Town, Stata, Zip Code) (MOTHER) 1024 TUNBRIDGE RD. BALT. MD. 21212 20b. Place of Disposition (Nama of cametary, crematory or other pla KING MEM • PARK 20a. Method of Disposition

1 Burial 2 Cramation 3 Ramoval from Stata Data 20c. Location - City or Town, Stata Department of Important: If any injury or AUG. 15,1998 BALT. MD. 4 Donation 5 Other (Specify) 21. Signefure of Funerel Sarvice Licensii 22. Nama and Addrass of Facility GARY L. ROLLINS FUNERAL HOME 110 WEST SOUTH ST. FRED. MD.

plicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, one cause on each line. 21701 Approximata Intervat Batwaan Onsat and Death 23a. Part1. Entar the disaasa, or conshock, or heart failure. List only **Physician** /Medical immediate Ceuse (Finel disaasa or conditior rasulting in daath) Examiner Examiner SEDSIS Sequantially list conditions, if eny, laading to immediata cause. Enfer Undarlying Ceuse (Disease or Injury that Initiated avants resulting in daath) Last · ACQUIRED IMMUNODEFICIENCY Physician/Medicai esn Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? END STAGE RINAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown py DIABETES MELLITUS 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy complation of causa of death? paga 2 1 Yas 2 No Be 25. Was case referred to medicat axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Naturel 2 Accidant 5 Pending 1 ☐ Yas 2 ☐ No invastigation 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - Af home, farm, straat, factory, offica building, etc. (Specify) 4 Homicida 1 Certifying Physicien: To the best of my knowledga, daath occurred et tha time, dete end place, and dua to tha causa(s) and manner es steled.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua fo the causa(s) and manner stated. 29a. Cartifiar Medicai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signatura and title of cartifiar 29c. Licensa number 29d. Date signed (Month, Day, Year)

Haspital.

State Registrar Thakkar. Union memorial 32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

of Vital Records,

or Attending Physician:

this

aftar death Director:

24 hours Hospital

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and the transfer of the state o

State of Maryland / Department of Health and Mental Hygiene 0

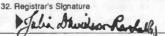
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altimore, Maryland 21215-0020	mmit. Pagas 1 and 2 should be filed within 72 hours after death with the Meryland poartment of Health and Mentel Hyolena.	portant: if item 27 is marked other than "naturel", or items 23s or 28s-f show by injury or other traumstic event, the Medical Examiner must be notified at

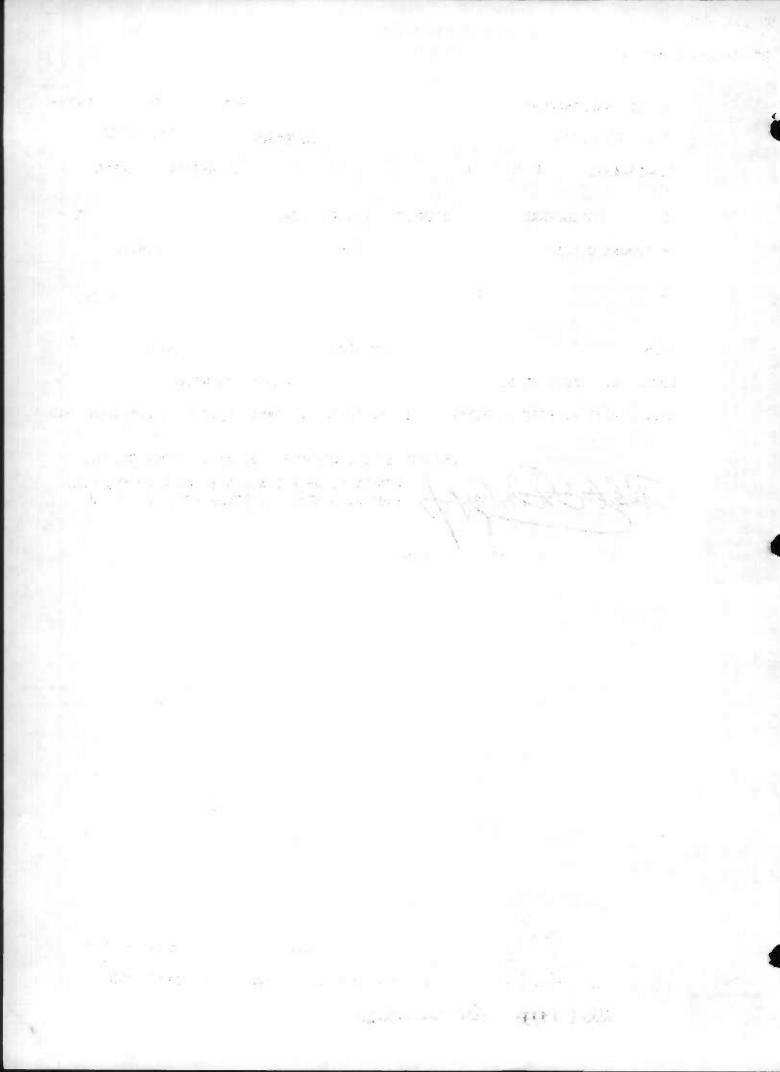
Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 9,1998 **Physician** 0440a SERGY HADJIBABOFF /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MONTGOMERY 14 FROUND CIRCLE BETHESDA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-4-1951 5 Social Security Number 9. Birtholace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2□ F Months Days TURKEY 47 220-56-4372 or Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No (CABIN JOHN) Director MD MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 14 Fround Circle 20818 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dales: 1 Never Married 2 ☐ Married 1 Yes 2√ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) ODD JOBS NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROBIN D. HADJIBABOFF MARTA YERSHOVA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sp.#281 Mt. View, CA 94040 MRS. ELFIYE N. POST (SISTER) 191 E. El Camino Real 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 Cremation 3 Removal from State 4 □Donation 5 □ Other (Specify) 8/14/98 FREDERICK, MD. RESTHAVEN MEM. GARDNES 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. W end on one 1201 N. MARKET ST. FREDERICK, MD. speck Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical liver Examiner Due to (or as a consequence of) Examiner The law requires that the death cartificets be axecuted physicien and tha burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 88 attanding for usa as signed by tha a d be dateched f 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy is certificate has director, page 2: 1 Yes 2 No 1 PYes 2 □ No or Attending Physician: 25. Was cese referred to medicel exeminer? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXes 2□ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funarel 27, Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No daeth. investigation 2 Accident after daetl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 4 Homicide C To the Hospital or within 24 hours aft To the Funeral Dicomplataly filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. Medical (Check only one) 2 Amedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. August 9, 1998 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Murid

State Registrar

AUG 1

31. Date filed (Month, Day, Year)





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 2 Month : 45 Edna D. 8 4a Fecility Name (If not institution, give street and nur 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Yaar Months Deys 5. Social Security Number Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) Months 1 M 2 □ F Yrs. 85 087-03-7367 May 15, 1913 New York Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2€ No Maryland Montgomery Germantown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12205 Major Drive 20876 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, 11. Meritel Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Spacify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Own home. 12 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Frank Knack Rabin Anna 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Ippolito, Sr.-Husband 12205 Major Drive, Germantown, Maryland 20876 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Buriel Cremetion 3 Removel from Stete Arlington National Cemetery 8/20/98 Ft. Meyer, Virginia 5 Other (Specify) 21. Signeture of Fundam Service Licens 22. Neme and Addrass of Fecility Olin L. Molesworth, P.A., Funeral Home ohert the disease, or complications that caused the death. Do not enter the mode of the mode of the standard and a characteristic are maryland that feilure. List only one ceuse on each line. 2087x2nate Intervel Between Onset end Death Immediate Cause (Finel disaase or condition resulting in deeth) 1200 Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest (900c anterio Sc Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopsy asporin Reaction winery troot inf 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical axeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Naturel 5 Pending

**Physician** /Medical Examiner

**Physician** 

/Medical

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Certification:

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3 ☐ Suicide

29a. Certifier

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28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, daeth occurred et the tima, deta end plece, and due to the cause(s) and mennar as steted.

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29c. License number

1 Yes

2 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Month Freddie John Jennings /Medical August 17, 1998 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Kent & Queen Annes Hospital Chestertown
If Under 24 Hrs. 8. Dat
Hours Min. (Md 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthpiece (State or Foreign Country) 1 □ M 2 □ F Days Yrs. Director 039-05-2577 June 19, 1916 West Warwick, RI Usuei Residence of Decedent death with the Maryland 10a. State show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified Director 1 ☐ Yes 2 No 28e-f Maryland Kent Kennedyville 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? or items 23e or 71198 Augustine Herman Highway 21645 Funeral United States 12. Wes Decedent Ever in U,S. Armed Forces?

DOXYes 2 □ No If Yes, Give Yeer or Detes: U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American indien, Bleck, White, etc. Pagas 1 end 2 should be filed within 72 hours eftar in ant of Health end Mentel Hygiene. Int: If Item 27 Is marked other than "netural", or ite 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White Specity: 3 ☐ Widowed 4 ☐ Divorced Completed Army 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 9 Boiler Maker/Steam Fitter Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be other traumatic Walter Jennings Bella (Last Name Unknown) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21645 19a. Informent's Name/Reletionship (Type, Print) permit. Pagas 1 and 2 s Department of Health er Important: If Item 27 Is eny injury or other trau 71198 Augustine Herman Highway, Kennedyville, MD ece of Disposition (Neme of Dete 20c. Location - City or Town, State Elizabeth M. Jennings/Wife Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ₺ Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Crumpton Cemetery/August 20, 1998Crumpton, Maryland 21. Signeture Funeral Service Licensee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. P. O. Box 270, Millington, Maryland 21651

239. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximately and adjusted the deeth. Approximately app Approximete Intervel Between Onset end Death **Physician** · Pulmonary arrest Immediete Ceuse (Finel diseese or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of). Examiner Multilobar polumon, a The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last Division of Vital Records, P.O. Box 68760, · Yarkinson's Physician/Medicai Due to (or es e consequence of) Pert II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown by 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy 2 DINO 1□ Yes 25 No 1 Yes or Attending Physician: Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 2 Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending Investigation 1. Natural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by tha fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. Medicai (Check only one) 29b. Signature end title of pertifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 20+1 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6602 Church Hill Road, Suite 200, Chestertown, Maryland 21620 Frederick Delboy, 2. Registrer's Signature 31. Date filed (Month, Day, Year) State AUG 1 9 1998 Registrar

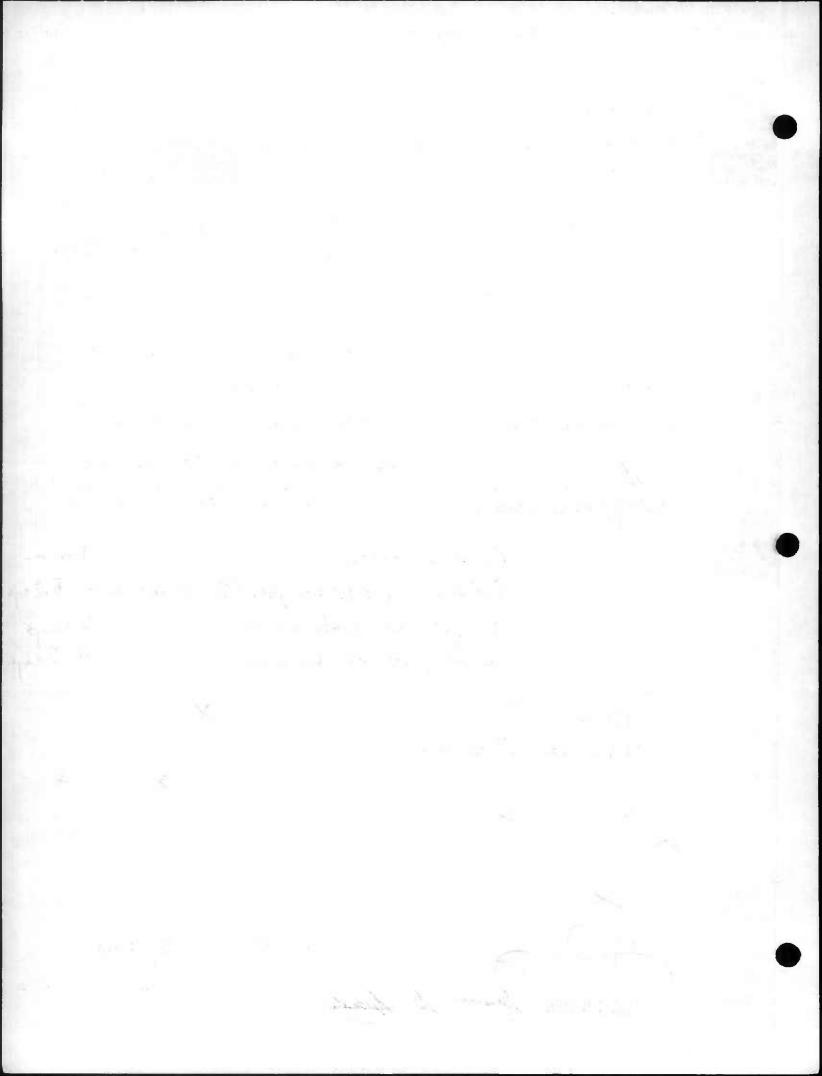
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Daath 3. Tima of Daath **Physician** August 11, 1998 Month Nancy Elizabeth Koons 6:00 am /Medical 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9210 Leidel Court Laurel Prince George 5. Social Security Number If Undar 24 Hrs. 8. Data of Birth (Month, Day, Aug 9, If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Days Hours 1 ☐ M 2 🗙 F Mary land 66 216-30-3823 Yrs. Director Usual Residence of Decadent the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director MD Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 death with 9210 Leidel Court 20708 items 23a USA Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 💆 No Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - Amarican Indian Black, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mertel Hygiene. Important: If item 27 is marked other than "natural", or itel any injury or other tharmatic event, the Medical Experiment. 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: Yas Give Specify White þ 3 Widowad 4 Divorced Completed 15. Dacedant's Education (Spacify only highast grada complated) 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elementary/Sacondary (0-12) College (1-4or 5+) Grade 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Howard W. Merson Mary Elizabeth Keys 19a. informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) James A. Koons /spouse 9210 Leidel Court, Laurel, Maryland 20708 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 8/14/98 Catonsville, Maryland Metro Crematory, Inc. 21. Signatu of Funaral Service Licen at 22. Nama and Addrass of Facility Donaldson Funeral Home, P.A. TE 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Physician Immediete Ceusa (Final disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leeding to immadiate causa. Enter Underlying Causa (Diseasa or injury that initiated avents rasulting in daath) Last Dua to (or es e consequance of): physician is the buriel Box 68760. Physician/Medical Dua to (or as a consequence of) use as Pop P.0. Part II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? hematoma 1 Yes No 3 Probably 4 Unknown Subdural signed b Records. þ 24b. Wera eutopsy findings available prior to complation of ceuse of daeth? page 2 should Completed 24a. Was an autopsy a No 1 ☐ Yes No 1 Yas certificate Division of Vital or Attending Physician: director, Be 25. Was casa rafarrad to medicel 26. Place of Death (Check only ona) axaminar' Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatiant 3 DOA After this the funeral Data of Injury (Month, Dey Year) 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accidant 5 Pending invastigation death. 1 ☐ Yas 2 ☐ No 3 ☐ Suicida 6 Could not ba 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida

efter deat filled in by within 24 hours of To the Funeral I Hospital completely the

Cartifying Physician: To the best of my knowladge, death occurred et the time, deta and place, and dua to tha causa(s) end menner es steled.

2 Medical Examinar: On the basis of axaminetion and/or investigation, in my opinion, daath occurred at the time, date end piece, end due to the ceuse(s) and manner statad. (Check only 29c. Licansa number 29d. Data signad (Month, Dey, Yeer)

29b. Signature and titla of certifier

29a. Certifia

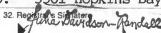
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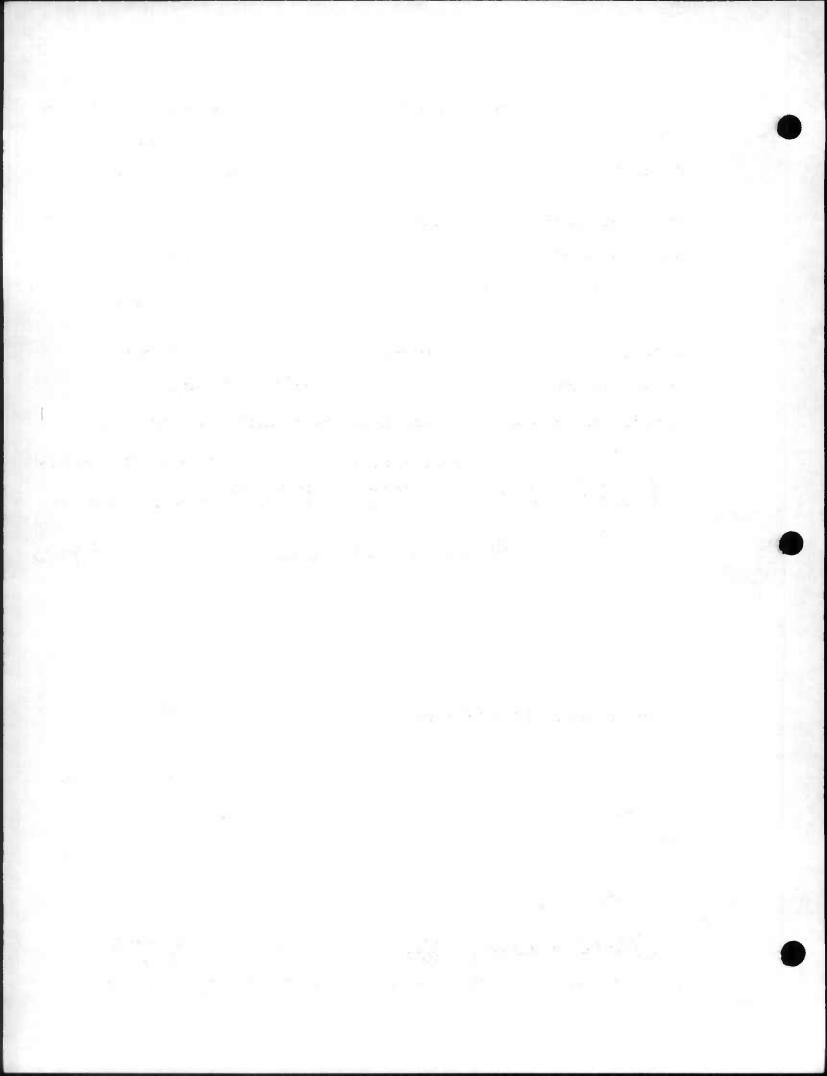
30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print)

5501 Hopkins Bayview Circle, Baltimore, Maryland 21224 Claudia H. Kawas, M.D. 31. Data filad (Month Day,

State Registrar

Medicai





State of Maryland / Department of Health and Mental Hygiene 🔾 🎗 Certificate of Death 1. Decedent'e Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** WILLIAM WALTER MULLIGAN AUGUST 16,1998 10;15am /Medical 4e. Feclifty Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** CHESTERTOWN KENT HOSPITAL KENT-OUEEN ANNES If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Forei Country) March 27, 1926 Brooklyn, NY 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplece (State or Foreign Country) **Funeral** Deys 1 M M 2 □ F Months 72 541-30-8479 Director Usuel Rasidance of Dacedant 10e. Stete 10b. County 10c City Town or Location 10d, Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at 1 X Yas 2 □ No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 124 Washington Ave 21620 U.S.A. 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puarto Rican, atc.) 14. Race - American Indian, 11. Meritel Status Black, Whita, etc. 1 M Yes 2 No If Yes, Give Yaar or Datas: 1941-1945 1 Nevar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 18b. Kind of Businass/Industry ified within 7 I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) permit. Pegas 1 and 2 should be filed with Department of Health and Mental Hygien important: if fem 27 is marked other that any injury or other trauments. Manager State Employment Agency 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stein Amanda Edwards Frank Joseph Mulligan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Mulligan/Son 124 Washington Avenue, Chestertown, Maryland 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burlal 2 Cramation 3 Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hurlock VA Cemetery/August 20, 1998 Hurlock, Maryland 21. Signature of Funaral Service Licenses 22. Nema end Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset end Death **Physician** Immediata Causa (Final disease or condition resulting in daath) e. CARDIO Pulmonary ARREST

Dua to (or as a consequence of):

b. Respiratory Faifure

Dua to (or es e consequence of): /Medical **Examiner** Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Diseesa or Injury that Initiated evants rasulting In daeth) Last and End Stage CHRONS OBSTRUTIVE Pulmonary
Dua to (or es e consequence of):

Disector P.O. Box 68760. attending physician for use as the buria Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Tes 2 No 3 Probably 4 Unknown pentension Sovere Anterior ascular Records, þ 24b. Ware autopsy findings evallable prior to completion of cause of deeth? Completed e, Congestine Heart Failure, 24a. Wes en autopsy PREVIOUS Hypotension, Hyporia 1 Yes 2 10 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica etaly filled in by the funeral director, Be 26. Placa of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 10 27. Manner of Death 28e. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Panding Invastigation 1 Yas 2 No wone 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcida 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowladga, daath occurred at tha tima, date end piece, end due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or investigetion, in my opinion, daath occurred at tha tima, data and place, end dua to the causa(s) and mannar stated. 29e. Certifian Medical 29b. Signetura and title of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) waln mis 023889 30. Nama and address of person who completed ceusa of death (Itam 23a) (Type, Print) +1 John E. ARKABAC TR MD, 945 WAShington Are chestentown, Med 21620

32 Begistrar's Signatura

State Registrar

2201 B : 3112

		Decedent's Neme (First, Mid	die lasti		(	epartme Certific	ate of	Death	2	Date of Dea	eg. No.	O	3. Time of Dea
Physicia /Medic		Owen Charles								Month ugust		1998	4:15 p.
Examin	er	4a. Fecility Name (If not institute Magnolia Hall						4b. City, Tow Cheste		ion of Death	4c. Count		
uneral Director		5. Social Security Number 219-07-4940	6. Sex 		(In yrs. last birtl	nday) If Un Monti	der 1 Year hs Days	If Under 2 Hours	Min.	Date of Birth (Month, Day )ec.4,	Year) 1917		oleca (State or Fol otry) ID
Mark Mark		Usual Residence of Decedent  10a. State 10b. Coun	ty		10c. City, Town	or Location		· · · · · · · · · · · · · · · · · · ·				,	Od. fnside City Li
tilled	ctor	MD Ken	t		Rock Ha	11							1 Ves 2□
23a or 2	Funeral Director	10e. Street end Number 5548 Boundary	Avenue			10f.	Zip Code	21661		1	0g. Citizen of U.S.A		ntry?
respectant of result and worlds register registers; or ferms 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Merried 2€ Ma 3 □ Widowed 4 □ Divorce	arried 132 Yes	Forces? s 2 ☐ No Give	ver in U,S. 0 1941- 1945		cedent of I specify Cub s 2 2 No	Hispanic Orig en, Mexican, Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ck, White,	can fndien, etc. Black
han "netur e Medical	Completed	(Specify only high Elementery/Secondary (0-12)	ent's Education ast grade completed College	d) (1-4or 5+			work dona T usa retire	pation during most od)	of working		16b. Kind of E		
ther t		8th 17. Father's Name (First, Middle	a, Last)			Labor	er	18. Mother	's Name (F	irst, Middla.	Lumbe		d
rked o	To Be	Edward Philli	ps							sting		,	
ie me		19e. tnformant's Name/Relation Mary Phillips									r, City or Town		
orn 27 other t		20e. Method of Disposition	- wife		20b. Place of	Disposition (	Name of				20c. Location		MD 21661
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Importan any injur		21. Signature of Funerel Service			naron (	-		ess of Facility		,	Perkin	-	
EES		Aguaras	Pank	6		Serv	ice,	P.O.Bo	x 143	, Rock	Hall,	MD 2	1661
physicia as the bur	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last	6 <i>A</i>	D	Die to for as a co	onsequenca	of):	o, all	lon L	Sesex	el .		
attand for us	clan		- d.	-								2	
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cata ha		Atual 1	FBM'Llai	tin.						1□ Y	es 2 PNo	10	Yes 2□ No
3 2	To Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 ☑ No	Hospitai:	Inpatient	t 2 ER/Outs	nationt 3	DOA Ot	har /		heck only or	na) enca 8 □Ot	har (Casai	641
五 元		27. Manner of Deeth 1	28e. Dat	e of tnjury onth, Day			28c. Inju Wo				ow injury occu		<i>y</i> /
Director: Aft	Certification:	2 Accident inves 3 Suicide 6 Could	tigation d not be mined 28e. Piac	Non	y - At home, fari	М	1 🗆	Yes 2□N		Location (S City or Tow	traat and Num n, Stata)	ber or Aur	al Routa Number,
	edicai	29a. Certifier (Check only one) 1 ☐ Certify 2 ☐ Medica	ing Physician: To the it Examiner: On the and ma	ne best of basis of e	examination and	death occurr or investigat	ed at the ti ion, in my	me, dete and opinion, death	place, and h occurred	due to the cat the time, d	ause(s) end mate and pleca	anner as s and due to	tated. the cause(s)
Toth	ž	29b. Signature end title of certif	er a 0 -		,		29c. Licen			2	9d. Date sign	ed (Month,	Day, Year)
		(li	ulas.	MI	\$			388			8/1	8190	<i>r</i>
	- 1	30. Name and address of eerso	who completed car	use of dea	ath (Item 23a) (T	ype, Print)		V- 44					
		John C. As	who completed car	e M.	1. 941	WA	Vicino.	In Th	10 1	du ten	Fores	711	117/1.

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G763 9-24-98 WR. Certificate of Death	Bee No	20010

Resthaven Memorial Gardens, Aug. 12, 1998 Frederick, MD

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Yes 2 No

Maryland

Race - American Indian, Black, White, etc.

20c. Location - City or Town, State

AUGUST 10, 1998

White

00:45 AM

Physician	1. Decedent's Nam	ne (First, Middle		ff older	1 DECVA	CVT	TD	7	2. Date of D Month	Death Day	Year	3. Ti
/Medical Examiner			Jason M		1 PECYN	ISKI,		b. City, Town, or			1998 ounty of Deal	th O
Funeral Director	UNIVERS: 5. Social Security N 213-53-59	Number 994	PITAL 6. Sex 10XM 2□ F	7. Age (In )	rrs. last birthday) Yrs.	If Under Months		If Under 24 Hrs Hours Min	8. Date of B	Birth (2007) 13, 199	9. Bir Co Man	thplace (Sountry) rylan
the Maryland 28a-f show nutfled at rector	Usual Residence of 10a. Stete  Maryland	10b. County	ederick	10c.	City, Town or Lo		rede	rick				10d. Insi
) fer deeth with the Mai frem 23e or 28e-1's fine main be notified fromeral Director	10e. Street and Nu 6418		oint Cour	t		10f. Zip	2170	3		U	S.A.	
(1215-0020 within 72 hours after death with the Maryland ans. than "natural", or items 23s or 28s-f show than "natural" or items 13s or 28s-f show its Medical Examination must be inclined at impleted by Funeral Director	11. Mantal Status 1∭ Never Man 3 □ Widowed	ried 2 Mam	12. Was Dec	edent Ever in orces? 2 X No ive		Was Dece if Yas, spe 1 ☐ Yas		ispanic Origin? (S in, Maxican, Puer Specify:	Specify Yas or Note Rican, etc.)		Race - Ame Black, Whit	
	(Spec		's Education it grade completed) College (		16a. Dece (Give life.	dent's Usua kind of wo DO NOT u Baby	ork done d se retired	during most of wo	rking	16b. Kind	of Business	/Industry
uld be filed Aental Hygi- rked other tic event, I	17. Fether's Neme		<sub>Last)</sub> hael PECY	NSKI,	SR.			18. Mother's Na Tara	me (First, Middle Lynn L			
CZNL	19e. informent's No. Ms. Debox		hip (Type, Print) LaGrave,	Grandm		_		end Number or R Street,				
Saltimore, emit. Pages 1 a Separtment of Hea mportant: If Item iny Injury or othe ince.	20a. Method of Dis 1 X Burial 2 4 ☐ Donation	Cremetion	3 □Removal from	State	b. Place of Dispo cemetary, cres esthaver				Date Allo 1		tion - City or	Town, Sta

**Physician** /Medical Examiner

Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-tran by Completed page 2 To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be Medical Certification: To

After this certificate

Division of Vital Records, P.O. Box 68760,

23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, only one ceuse on each fine.	D 21701 Approximata Interval Batween Onset end Deeth
Immediate Cause (Final disease or condition resulting in death)	a. HEMORRHAGIC INFARCT OF BRAINSTEM	
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate	b b Due to (or as a consequenca of):	
cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	cDua to (or as a consaquence of):	
	d	
Pert II. Other algnificant condition	ns contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the contribute of the contribution of the cont	

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2□ No 25. Was case referred to medical examiner?

1 ☑ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier

OCME

who completed cause of deeth (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)
AUG 1 2

LARON

32. Registrar's Signature a daudian back

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 8.05 AM 4b, City, Town, or Location of Death Hagestown 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth Washington 1405 Washing County If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. (Month, Day, 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign Country) Washington, D.C 579-48-6021 100 20F Months Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 ☐ Yes 20 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4830 Coxey Brown Road 21702 S. A. 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorcad 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrician Foreman Electrical 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Clay Carr Peyton, Sr. Mari Catherine Green 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ruth F. Peyton - Wife 4830 Coxey Brown Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State N Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Resthaven Memorial Garden's 8-12-98 Frederick, Maryland 21. Signature of Edfleral Service Lieupsee 22. Name and Address of Fecility Stauffer Funeral Home, P. A. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart figure. List only one cause on each year. 1621 Opossumtown Pike, Frederick, Maryland 21702 Approximete Intervel Between Onset end Deeth Cerebral Immediate Ceuse (Final disease or condition resulting in death) Carcina Due to (or es e consequence of) Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 Tho 3 ☐ Probably 4 ☐ Unknown Anone 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed?

**Physician** /Medical Examiner

Depertment o Important: If i any injury or

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

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Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

I Hygiene.

. Pages 1 end 2 should be filed w tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

death with the Marylend

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner the burief-trer Physician/Medical page 2 should be detact þ Be Completed 2 funeral In by the

or attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the ettending physician end

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2000 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 27. Menner of Deeth Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Exeminer: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signeture end title 29c. License number 29d. Date signed (Month, Day, Year)

Johnson Ir, Frederick

State Registrar 31. Date filed (Month, Day, Year) AUG 1 1

ra

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

188 32. Registrer's Signeture

To the Hospital or within 24 hours eft To the Funerel Di completely filled In

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 4c, 8/10/98, M.W.O., Howard Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 8 **Physician** V///e :05Am rivene /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner B-/7: MO CO.
If Under 24 Hrs. 8. Date
Hours Min. (Mon. None Medica System

last birthday) If Under 1 Year

Months Days of Mary University land 9. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□F 218-26-6837 68 Maryland Director Feb 2, Usual Residence of Deceden the Marylend 10d. Insida City Limits 10a State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 20 No Director Maryland Howard Ellicott City 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9217 Furrow Avenue 21042 United States Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorcad permit. Pages 1 and 2 should be filed within 72 hours Department of Health end Mental Hygiane. Important: if item 27 is marked other than "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Contracting Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Orville Sylvester Scrivener Rosalie Margaret Tarsia 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hazel H. Scrivener/Wife 9217 Furrow Avenue Ellicott City MD 21042 other 1 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, Stata or 1 Burial 2 □ Cramation 3 □ Ramoval from State Injury o 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Cemetery 8-8-98 Marriottsville, MD 22. Name and Address of Facility
Harry H. Witzke's Family Funeral Home, Inc. 21. Signature of Funeral Servica Licensee Them a College 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Tension Freumotho disaase or condition resulting in death) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last ettending physician and for usa es the bunal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of) Part II. Other algnificant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by it 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Emphysema Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy Statles Post Bullectomy completion of cause of death? has 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata or Attending Physician: eftar death. Director: After this carific director, 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completaly filled in by 4 Homicide To the Hospital e within 24 hours e To the Funeral D

5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

Medical

29a. Cartifiar

(Check only one)

1/1chcel

29b. Signature and title of cartifian

State Registrar

0 1998

Banks

mo

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S. GIRENE

2 Certifying Physicien: To the best of my knowledge, death occurred at the tima, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

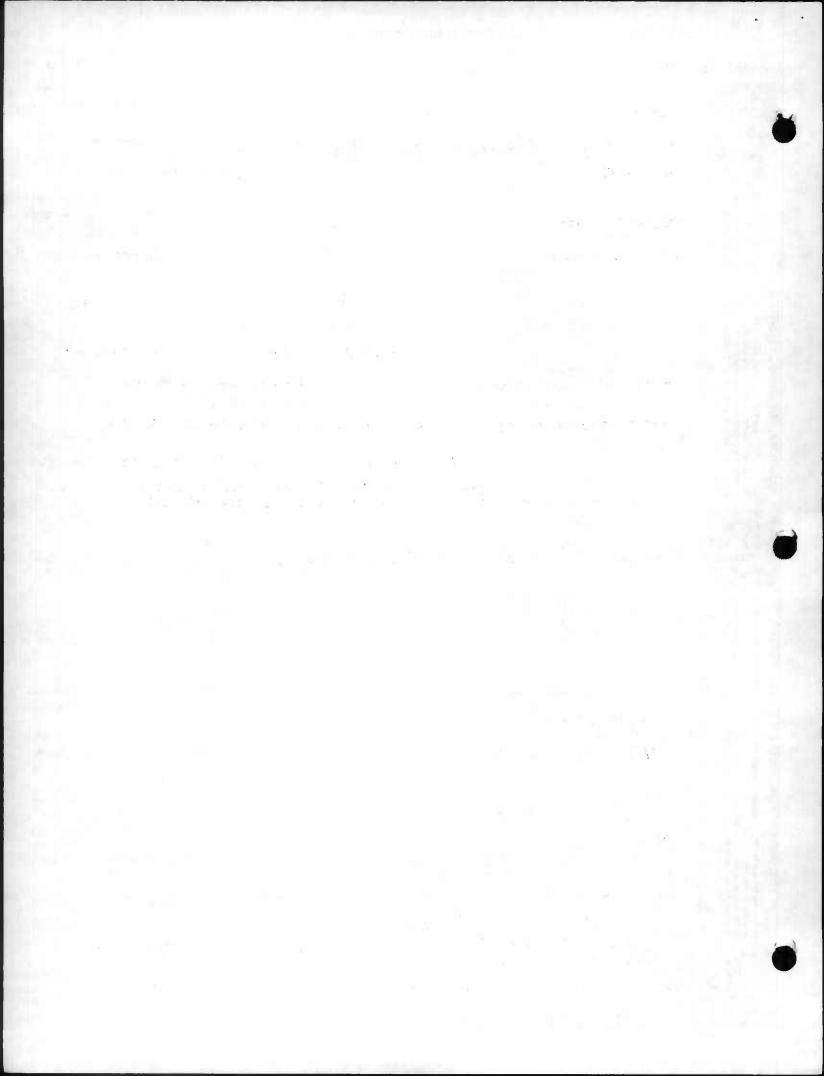
29c. License number

P11216

St Bettimore, MO

29d. Date signed (Month, Day, Year)

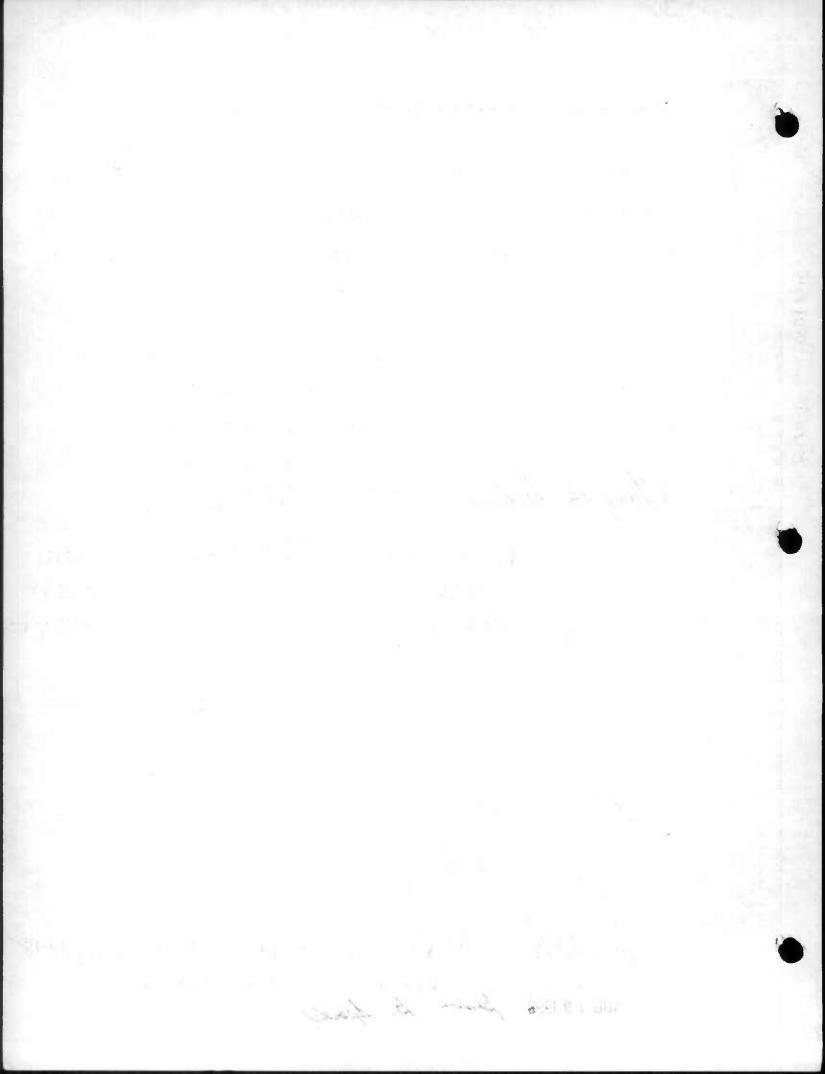
**DHMH 16 Rev 6/95** 



						Ce	ertificate c	of Death	7		Reg. No.		
		1. Decedent's Na	me (First, Middle, Li	ast)						2. Date of De Month	eth Dey	Yeer	3. Time of Deeth
Physi /Med		Maye	e Lily S	Shaum						August		1998	4:45 P.N
Exam			(If not institution, gi						own, or L	ocation of Deeti Ck	h 4c. Count	y of Deeth deric	k
Funera Directo		5. Social Security 216–05–2		Sex 1 M 2 F		s. last birthday	Months Da		Min.	8. Date of Bir Mar. 18	th Year 1905	9. Birthp Mary	lace (State or Foreign
	"	Usual Residence					J J					_	
Marylend f show	lor	10a. State MD	10b. County Freder	ick		City, Town or L Frederi						1	0d. Inside City Limits 1
with the a or 28e Le noth	Director	10e. Street and N 200 E	umber last 16th	st.		-11	10f. Zip Cod	<sup>°</sup> 21701			10g. Citizen of US		ntry?
17215-0020 within 72 hours efter death with the Manyland ene. than "natural; or items 23s or 28s-1 show in Medical Examinet must be notified as	by Funeral		rried 2 Married	Armed F	2X No	U,S. 13.	Was Decedent of If Yes, specify C	uban, Mexica	an, Puerto	pecify Yes or No Rican, etc.)		ce - Americ ick, White, fy: Whi	etc.
15-002 72 hours "natural",	3	10	15. Decedent's E	ducetion		16e. Dece	edent's Usual Oc	cupation	-1 -1	1. t	16b. Kind of E	Business/Inc	dustry
d 21215 filed within 7 Hygiene. other then 'n	Completed	Elementary/Sec	ecify only highest gr condary (0-12)		) (1-4or 5+)		e kind of work do DO NOT use re amstress		st of work	king	Clo	thing	Manu.
S da a	o Be	17. Fether's Name	e (First, Middle, Las Benjami		or Knod	le					, Maiden Suma trude R		
	-		Name/Reletionship		ıghter		ling Address (Str Eden Cou					, State, Zip	Code)
of Hen			sposition  Cremation 3 [ 5 Other (Speci		Ctoto	cemetery, cre	osition (Name of ematory or other of CC Cem.	place)	0	Date 08/13	20c. Location Taneyto		
Baltim permit. Peg Deperment Important: I any Injury o		21. Signature of	Suneral Service Lice	Off-Oc.	M00534		22. Name and Ad				neral H		21787
Physician /Medica		Mock, or he	the disease, or consent failure. List only	nplicetions fhat one cause on	caused the de each line.								Approximete interval Between Onset and Death
Examine	Ç. /	Immediate Cause disease or condit resulting in deeth	ion	θ		IROSE (or as e conse					,		48 hrs
Box 68760, aath certificate be executed attending physician end for use es the buriel-transit	ai Examiner	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of	or injury	b	Due to (or es a consequence of):								
ox 68760, certificete be exiding physician e	/Medical	thet initiated even resulting in death	its	d	Due to	(or as a conse	quence of):					1	
death o	ciar									11 227 234	HVASS IN HE		
O & F	Physician	Part II. Other algr	DI AB		death but not re	esulting in the	underlying cause	given in Pari	t I.		Yee 2 No		o the cause of death? bably 4 ☐ Unknown
requires requires hould be	leted by			MYOCA	ROVE	MEARC	7102				s en eutopsy ormed?	ev	dere autopsy findings reilable prior to ompletion of ceuse deeth?
_ F # &	Completed		DEHY	DRATIO	~ 7	SUEUM	2) 2/14			10	Yes 2/5 No		Yes 2□ No
r Vital I ysiclen: The s certificete director, per	e e	25. Was case refe examiner?			,		1	-	ce of Dea	th (Check only	one)		
- 5 w 0	2		440	Hospital:	Appatient 2	☐ ER/Outpatie	ent 3 DOA		Jursing H	ome 5□Res	idence 6 □Ot	her (Specif	fy)
After fune	ation:	27. Manner of Dec 1 Alatural 2 Accident	5 Pending investigation	on	of Injury nth, Day Year)	28b. Time Injury		njuryat Work? I∐Yes 2[	□ No	28d. Describe	how injury occu	irred	
ا المالات	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. Plac	e of Injury - At ding, etc. (Spec	home, farm, s	treet, factory, offi	се			(Street and Num wn, State)	ber or Rura	al Route Number,
DIVISION To the Hospital or Attention within 24 hours effer deat To the Funeral Director: completely filled in by the	edicai C	29e. Certifier (Check only one)	1 ← Certifying Pl 2 ← Medical Exa	miner: On the b									
To the within To the	Me	29b. Signeture en	d title of confiler		MO			ense number			29d. Date sign	ed (Month,	Day, Year)
,			dress of person who	completed cau	ise of deeth (Ite	em 23e) (Type							
S	tate	31. Date filed (M	DUCH P	32.1	Pegistrer's Sig	nature	ERICK S	7, 6	ALK	RSUILLE	WD 3	1793	
Regis	trar		7 4 19	30 4	an alle	disorbes	60						

Amended #19a, 8/27/98, CWPlease Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended # 1, 08/19/98, TM, Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death **Physician** Mae August 1312 4e. Fecility Name (If not institution, give street end number; 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Daath **Examiner** Union Hospital Elkton
If Under 24 Hrs.
Hours Min. If Under 1 Yaar 5. Sociel Sacurity Number 6 Sex 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1□M 2876 216-54-8874 Yrs 78 Director 11, 1920 Kent County, MD April Usuel Rasidanca of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23a or 28a-f shoviner must be notified at Kent Maryland Golts 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 33609 Sassafras Caldwell Road 21637 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes StyNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whita, etc. traumatic event, the Medical Examiner 1 □ Never Marriad 2 □ Married 5 þ 1 ☐ Yes XX No White ₩idowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: if item 27 is marked other than \* Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic/Own Home 17. Fether's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be John Edward Waecker Ann Catherine Duling 19a. Informent's Name/Reletionship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Rhesa Antone/Son RepresentativeBox 201, C.O.RD 47, Clayton, DE 19938 other 1 Baltimore, 20e. Mathod of Disposition 20b. Placa of Disposition (Name of cematary, cremetory or other place) 20c. Location - City or Town, Stete Stevensville, Maryland 10 1 ☐ Burial 2 X Cremetion 3 ☐ Ramoval from State Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC/August 17, 1998 21. Signeture of Juneral Service Licenson 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. P. O. Box 270, Millington, Maryland 21651 Shock, or hear failure. List only one cause on each lina. Onsal and Deeth **Physiclan** Immedieta Cause (Final diseese or condition resulting in deeth) iscous /Medical **Examiner** Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be deteched for use as the bunal-transit Sequentially list conditions, if eny, laading to immedieta cause. Enter Underlying Ceuse (Disease or injury that initieted events rasulting in deeth) Last Due to (or as e consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contribute to the cause of deeth? s been signed by the should be detach 1 Nos 2 No 3 Probably 4 ☐ Unknown þ Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? 2 NO 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to madical axeminer? Be 26. Piece of Deeth (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 29a. Cartifier 1 🕒 Certifying Phyeician: To the bast of my knowledge, death occurred at tha time, date end plece, end due to tha ceusa(s) end mannar as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and mennar stated. 29b. Signeture and tale of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 7 odress of parson who completed cause of death (Item 23e) (Type, Print) 30. Name 3+ w. Hig State Registrar



State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, La	st)		cate of		2. Dete of Deeth			. Time of Death
Physic /Medi		Gloria J. Walk	er				Month Aug. 19	Dey 9,1998	Yeer 3	9:00 AM
Exami		4e. Fecility Neme (If not institution, giv 1312 Sudlersvi				4b. City, Town, or Lo Sudlers	cation of Death	4c. County		nne's
Funeral Director		5. Sociel Security Number 6. S			Inder 1 Year oths Deys		8. Dete of Birth (Month, Dey, ) Jan.7,	(ear)		(Stete or Foreign
Maryland f show	ō	Usuel Residence of Decedent  10e. Stete 10b. County No. Md. NY Queen 7	2290	. City, Town or Location		Westbury			10d. i	Inside City Limits
deeth with the Maryland ms 23s or 28s-f show	Funeral Director	10e. Street end Number 531 Chu		10	f. Zip Code	668 115		U.S.	/hat Country?	
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Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical examiner?	Hospitel:		100	26. Place of Deeth	(Check only one)			
£ F =	. To	1 Yes 225No  27. Menner of Death	1 LI Inpatient	2 □ ER/Outpetient 3		4 Unursing Hor	ne 5 Resident			
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To the Hospital or All within 24 hours effer of To the Funeral Directompletely filled in by	-	4 Homicide determined	building, etc. (Sp.				28f. Location (Stre City or Town,	Stete)		
Fun etely	Medical	29e. Certifier (Check only one) (Check only one)	raicien: To the best of my liner: On the basis of examend menner steted.	knowledge, deeth occu inetion end/or Investige	rred et the tire etion, in my o	ne, dete end plece, e plnion, deeth occurre	nd due to the cau id at the time, date	se(s) end mer e end place, e	nner es steted nd due to the	l. ceuse(s)
Vithin Fo the compl	Me	29b. Signature and title of certifier			29c. Licens	e number	290	. Date signed	(Month, Day,	Year)
	15	X WOOIL			DII	7/ 77	ŀ		4.0	1000
	15	30. Name end eddress of person who d	ompleted series of death to	Nom 02a) /T == 0.1 0	19	16 QT		Aug	1. 19,	1998

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Kyle E. Warren August 12 1998 1:15pm 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death 4813 Roundhill Road Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) June 30, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days M 2□F Months Hours Yrs 219-38-6837 58 1940 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 XNo Maryland Howard Ellicott City 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 4813 Roundhill Road 21043 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No tf Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2X No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Manager Westinghouse 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Kenneth Hoffman Warren Catherine Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Judith L. Warren/Wife 4813 Roundhill Road Ellicott City, MD 21043 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 8-13-98 Catonsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. a Collins Dh. 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Intervel Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es a consequence of):

Physician /Medical Examiner

Department of important: If its any injury or o

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

the Menyland

Pages 1 and 2 should be filed within 72 hours efter death with 1 and of Health and Mental Hygione.
ante if item 27 is marked other than "naturel", or items 23a or 3 ury or other traumatic event, I'm Mental Exammer marker

Baltimore, Maryland 21215-0020

ettending physician end for use es the buriel-trensit signed by the e been sig hes

Physician/Medical Examiner by Completed certificate he Be Certification: To this After t

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: Director: A To the Hospital o within 24 hours eff To the Funeral DI completely filled in

10

State Registrar

edicai

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?  1 Yes 2 ONo 3 Probably 4 Unknown
		24a. Was an eutopsy performed?  24b. Were autopsy findings aveilable prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
25. Wes case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ② No	Hospitel: 1 tnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death  1 SNatural 5 Pending 2 Accident investigat	(Month, Dey Year) Injury Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no determine		28f. Location (Street end Number or Rurel Route Number, City or Town, State)
	thysician: To the best of my knowledge, death occurred at the time, date and place, a sminer: On the basis of examinetion and/or investigation, in my opinion, death occurre and manner stated.	

29c. License number

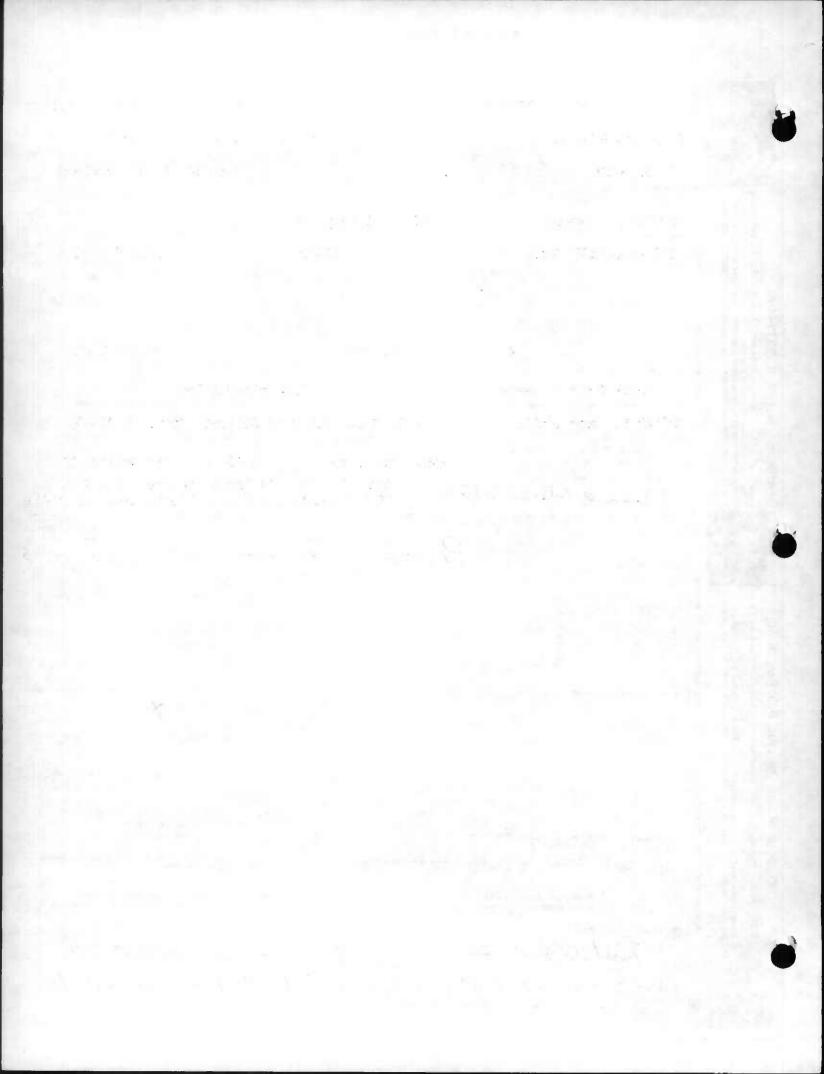
29d. Date signed (Month, Day, Year)

29b. Signeture and title of certifier

August 13, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

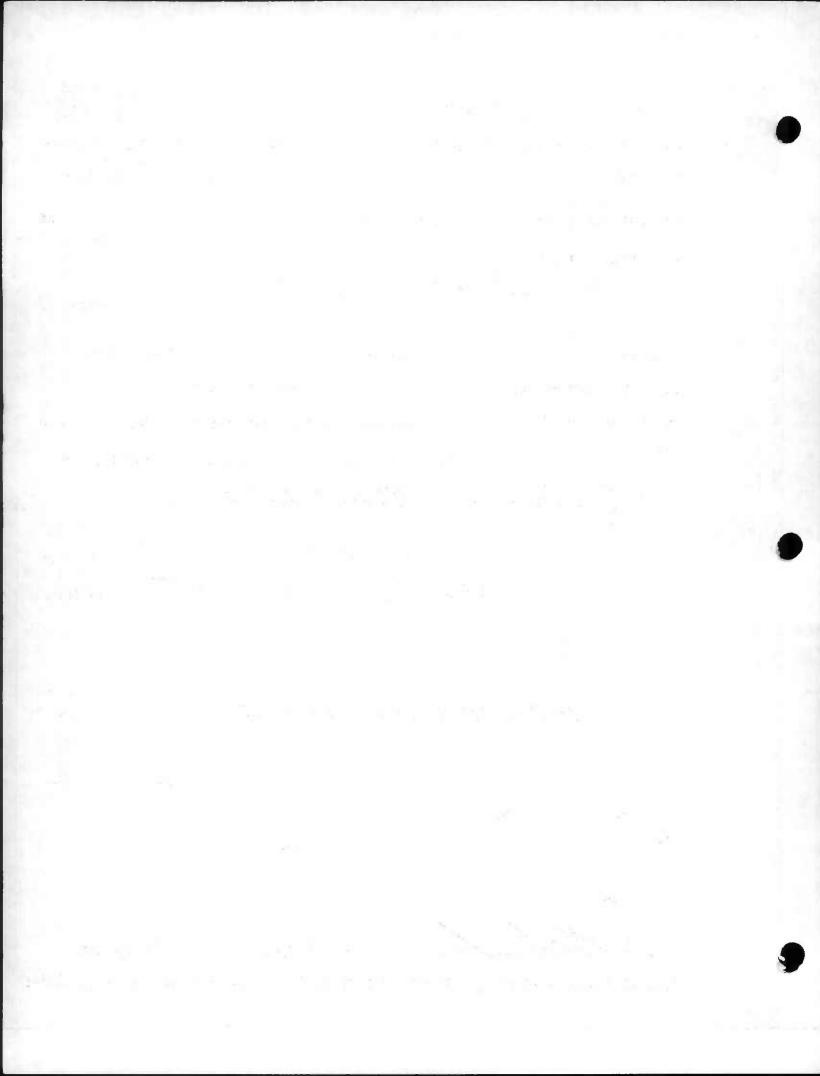
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or 28 or not	10e. Street and Number			10f.	Zip Code				10g. Citizan of	Whet Cour	ntry?
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i item 27 is marke r other trsumatic	20a. Mathod of Disposition		20b. Piace 0	f Disposition (f	vema of			Data	20c. Location		
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16

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Lukeo 31, Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201

Registrar

和6 20 1998

32. Registrer's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	A David No. No. of the A. A. A. A. A. A. A. A. A. A. A. A. A.		Certific	ate of Death	-	leg. No.	
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r 28	Director	10e. Street end Number		10f.	Zip Code		log. Citizen of W	het Country?
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- N -		Wm. H. Warren,		12416 H	Fountain Dr	. Clark	sburg,	MD 20871
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State of Maryland / Department of Health and Mental Hygiene () 26588 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Ruth E Zimmerman August 10. 1998 4:25 P.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Frederick Frederick Memorial Hospital Frederick If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Days Hours Yrs. 214-10-1104 Director June 22,1913 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23s or 28s-1 show Maryland Frederick Frederick 1 Tyes 27 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6398 Overbrook Circle 21702 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give altimore. Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White P 3€Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 permit. Fages 1 and 2 should be filed Department of Health and Mental Hygi Important. If then 27 Is marked other any Injury or other traumatic event, I 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Jones Ressie BOONE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Miss Doris J. Zimmerman/Daughter 6398 Overbrook Circle, Frederick, Maryland 21702 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Aug 11,1998 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 E Church St, Frederick, MD 21701 MO0706 operson elle 23a. Pertl. Enter the diserse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Se esn ettending p ed by the e Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown py 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attanding Physician: after death. Director: After this certific funerel director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 XNo Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) completely filled in by 4 Homiclde Hospital 24 hours a 24 hours a 1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the F 29d. Date sloned (Month. Day, Year) 29b. Signature and title 29c. License number 30. Name and address of purion who completed cause of death (Item 23a) (Type, Print) 32. Registrer's Signature

State Registrar

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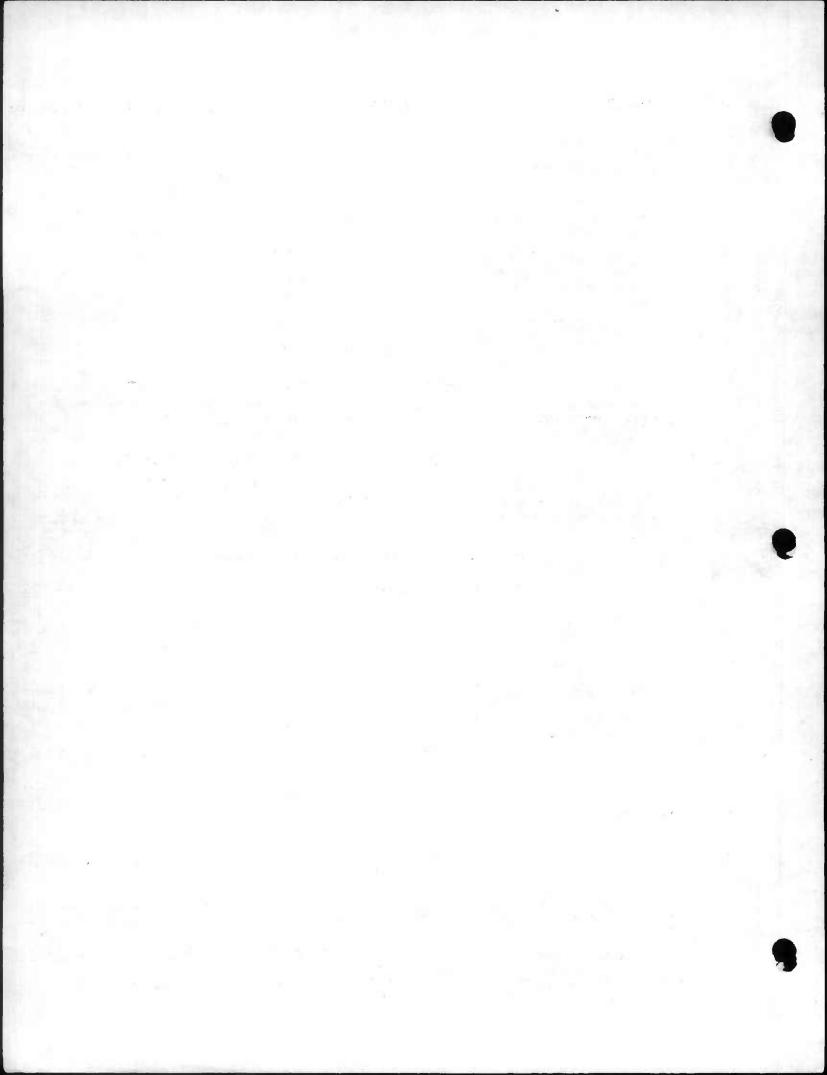
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician HOWARD ARNOFF 2/05 PN 26,1998 August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL THE Johns Hopkins
5. Social Security Number 6. Sex Baltimore City N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 11XM 20 F Yrs 275-30-9814 Director 61 DEC. 20, OHIO Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location worde r than "natural", or leams 23s or 28s-f show the Medical Examiner must be notified at 1 Tyes 2 No Director MD PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9006 HORTON ROAD 20708 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 72 hours after MXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within i Department of Health and Mental Hyglene. Important: If them 27 is marked other than \*n any Injury or other traumatic event, one head bota. Elementary/Secondary (0-12) College (1-4or 5+) AVIATION PSYCHOLOGIST NAVY DEPARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 ARNOFF SAM TILLIE KATZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAUREL, MD 20708 JUDITH ARNOFF (WIFE) 9006 HORTON ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) JUDEAN MEMORIAL GARDENS 18/28/98 OLNEY, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 eur's 23a Page Filter the disease, or compliance is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and a cardiac or re Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical . INTERSTITIAL PULMONARY FIBROSIS MONTHS Examiner Due to (or as a consequence of) SCIERODERMA YEARS physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): signed by the at d be datached for 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d Describe how injury occurred 28c. Injury at Work? O After Hospital or Attending 1 Natural 5 Pending investigation Et hours after deeth.
 Funeral Director: Ah sletch filled in by the fur 1 Tyes 2 No 2 Accident Division 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Inducts Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the To the Hosp within 24 ho To the Fund completely fi Medical (Check only one) er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN CHENG, MD N. WOLFE ST. , BALTIMORE, MD 21287 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 1998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Dorothy M. Alford /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 5AM 4e. Fecility Name (If not institution, give street end number) **Examiner** Mariner Health of Forest Hill Forest Hill Harford Hours Min. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year **Funeral** 1 M 2 XX Months Days 69 Yrs. 250-30-9188 Director Feb. 14, 1929 Usual Residence of Decedent pemit. Pegas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, its Medical Examinar must be notified anone. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Yes 2 No n/a Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2015 E. Lafayette Ave. 21213 USA 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes, Give Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Ricen, atc.) 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced **Black**  Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Hospital 12th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumama) Be 0 Boyd Matthew Mary Jane Ashford 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Fitzhugh Alford/son 804 Tiffany Trail Abingdon, MD 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1 Mt. Calvary Glen Burnie, MD atura of Funeral Sarvice Licensaa 22. Name end Address of Facility

James A. Morton & sons Funeral Home 1701 Laurens St. Balto., MD Mos LIN 234 Fart1. Enter the disease, or complications that ceused the daath. Do not enter the mode of dying, such as cerdiac or respiretory errest, nock, or heart failure. List only one cause on each line. Onsat end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) dente **Examiner** Due to (or es e consequence of): Examiner Al-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequance of): The lew raquiras that the death Part II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Pert I. 23b. Did tobecco use contribute to the cause of death? be datachad 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24a. Wes en autopsy page 2 should Completed 1 Tyes 2 No or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this nours after death.

neral Director: After this y filled In by the funeral d 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral D Hospital 1 Pertifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier (Check only one) 29b. Signature end title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) 10 august 28, 1958 032275 30. Name end eddress of person who comequie of deeth (Item 23e) (Type, Print) 5 GK W. MAC 2)0 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State SEP 0 1 1998 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#1 per Phy G763 9/1/98 EW 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death ARISDALE Airsdale Month GERALD VAN AUGUST 2.32 PM 26 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth HARBOR HOSPITAL CENTER BALTIMORE Baltimore City If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year)

April 23, 1923 N. Dakota 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 396-14-2909 15 M 2□ F 75 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 103 B North Charter Road United States 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Elementary School Principal Education 5+ 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fathar's Neme (First, Middle, Last) Glenn Percy Van Airsdale Sudie Frances Ashley 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2130 Marston Rd. New Windsor, MD 21776 Kim Strine/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) August 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 28, 1998 Catonsville, MD Metro Crematory of Funeral Service Licenses 22. Name and Address of Fecility Kirkley-Ruddick Funeral Home bavy 421 Crain Hwy. S.E. GLen Burnie, MD 21061 23e. Pert1. Enter the disaasa, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List on one ceuse on each line. Approximete Interval Between Onset end Death GHRS Immediate Cause (Finel ASPIRATION PNEUMONIA diseese or condition rasulting in deeth) Due to (or es e consequence of): 26 DAYS PERFORATED TRANSVERSE COLON Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseasa or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Z6DAYS COLON CARCINOMA Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? ANGINA PECTORIS 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred

Examiner Examiner Physician/Medical ğ Completed

Box 6876

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

10a. State

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

i Hygiena.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any Injury or other traumatic avent aptas.

**Physician** 

/Medical

72 hours after death

Baitimore, Maryland 21215-0020

Director

Funeral

Completed

Be

Be 2

this edical Certification: To the Hospital or Attanding death. Director: / after

within 24 hours aft To the Funeral Di completely filled in 5

State

Registrar

25. Wes case referred to medical axaminar? 1 Yes 2 No 27. Menner of Death 2 Accident 3 ☐ Suicide

29b. Signeture end title of pertiller

4 ☐ Homicide

29a. Certifier (Check only one) 5 Panding investigation 6 Could not be

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stele)

M.D

29c. License number P 11084

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

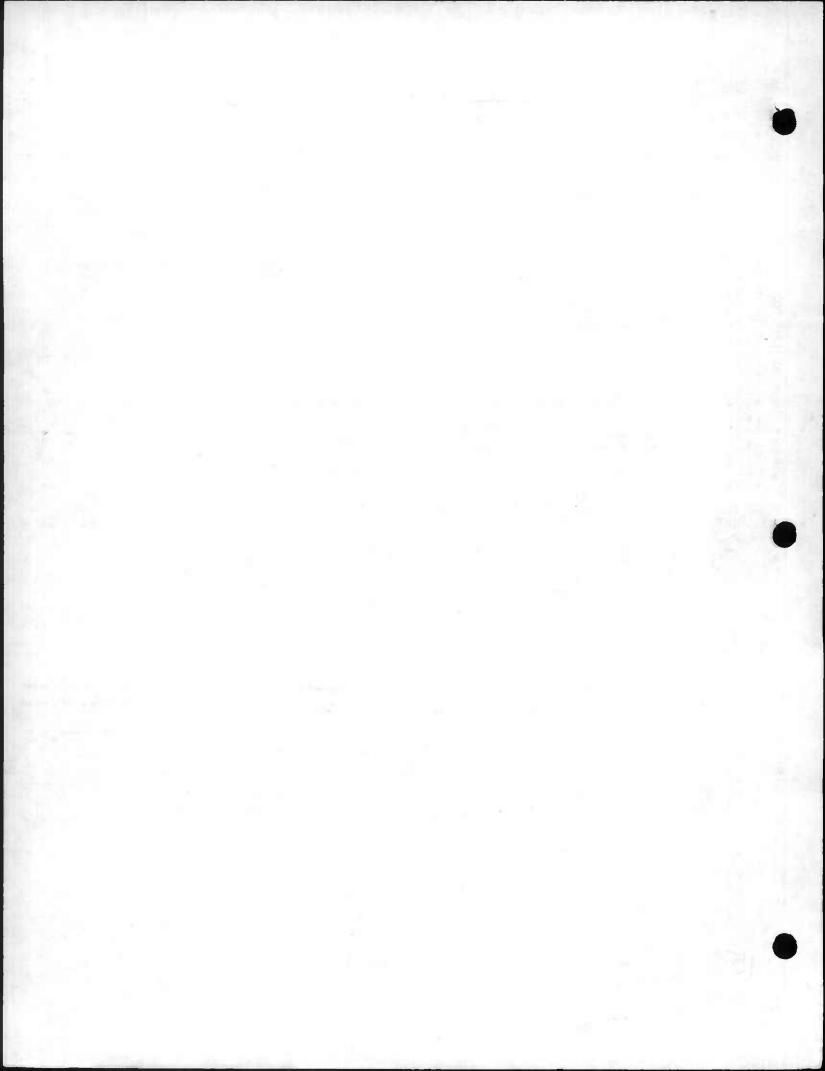
29d. Date signed (Month, Day, Year) AUGUST 26TH 1998

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) HARBOR HOSPITAL CENTER, 3001 S. HANOVER STREET, BALTIMORE, MD 21225 BINDU GEDRGE,

31. Dete filed (Month, Dey, Year) 1 1998

SEP

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene

26592 Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** Mildred Burns-Schroeder 29, 5:50 AM 1998 August /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Undar 24 Hrs. 5. Sociel Security Number 7. Age (in vrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2XF Months Devs Hours Min 75 Yrs. Maryland 212-05-9445 Sept. 12. 1922 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, in Medical Examinet must be reserved. 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Directo Maryland Baltimore. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 38 Acorn Circle, Apt. 204 21286 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Rece - Amaricen Indien. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hair Salon 12th grade 18. Mothar's Nama (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Frederick Wiegand Katherine Eberwein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Pnnt) Cheryl Ruth Yarneth (daughter) 11903 Woodberry Place, Kingsville, MD 20b. Plece of Disposition (Neme of cemetery, cremetery or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State Dulaney Valley Mem'l Gar. 9/2/98 Timonium. Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signatura of Funeral Sarvice Licansee Buran a 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) colon emcer 9 months Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): Schroeder 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o 1 Yes 2 No 3 Probably 4 Unknown à ď by Records, 24b. Ware eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No confilicate 0 Vital 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospica 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Division of 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 10 Certification: 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident tonko 6 Could not be determined 3 ☐ Suicide 28f. Locetion (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner steted. 29a. Certifier Medical (Check only one) 8 within 2 To the I å 29c. License number 29d Date signed (Month, Dey, Year) 0 un ed ceuse of death (I)om 23e) (Type, Print) N. Charles St. Balto. 32. Registrar's Signeture 31. Dete filed (Month, Dey, Year) Registrar **DHMH 16 Rev 6/95** 

Burns

Company to ment 800118 07

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month ugust 5156 AM LEON BROWN 26 **JESSE** 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth of 5. Sociel Security Number Balbimere 3albunare N/A 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Min 1₩ 2□ F Months Deys Hours Yrs. 216-36-4114 57 3 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10e State 10h Count 10c. City. Town or Location N/A XX Yes 2 No MARYLAND BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2518 N. LONGWOOD STREET 21216 US 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married XX Married 1 ☐ YesXXX No Specify: Specify: BLK. 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 SALESMAN ALCOHOL 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) HARVEY BROWN **EVA** BUTLER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 2518 N. LONGWOOD ST. BALTIO., MD. 21216 ELEANOR BROWN (WIFE) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 8/3/98 Burial 2 Cremetion 3 Removal from State BALTIO., MD. LOUDON PARK CEMETERY 4 Donetion 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E.L. PHILLIPS FUNERAL HOME PA CFSP Decta 1721-27 N. MONROE ST. BALTIO., MD. 21217 23a. Pert1. Enter the disease, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Ceuse (Finel Homosrhagic diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 PrUnknown Hyperbenson 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? wcho her berdeung 24e. Wes en eutopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpetient 3 DOA

/Medical Examiner Hrans

**Physician** 

**Physician** 

Examiner

**Funeral** 

Director

res 23e or 3

the Medical Examiner ma

permit. Pages 1 and 2 should be tiled within 72 hours ather Department of Health and Mental Hygiena. Important: If less 27 is merked other then "natural", or its any injury or other traumatic event, the Medical Examina

DOWN Maryland 21215-0020

Baltimore,

/Medical

Director

Funeral

by

Completed

89

Physician/Medical Examiner þ Completed director, Certification: To

Be

Medical

27. Manner of Death

1 Naturel

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Division of Vital Records, P.O. Box 68761 signed by the a irector, page 2 s or Attanding Physician: this funeral After s after des. in 24 hou... the Funeral Dirac

To the Hosp within 24 ho To the Fune completely f

State Registrar

28c. Injury et Work?

1 Yes 2 No

\*\*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signature end title of certifier

29c. License number

28d. Describe how injury occurred

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28a. Dete of Injury (Month, Dey Year)

Sinai Baltomore, Baltonnore MD. 21215 Wiederkel Hospital et 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture

28b. Time of

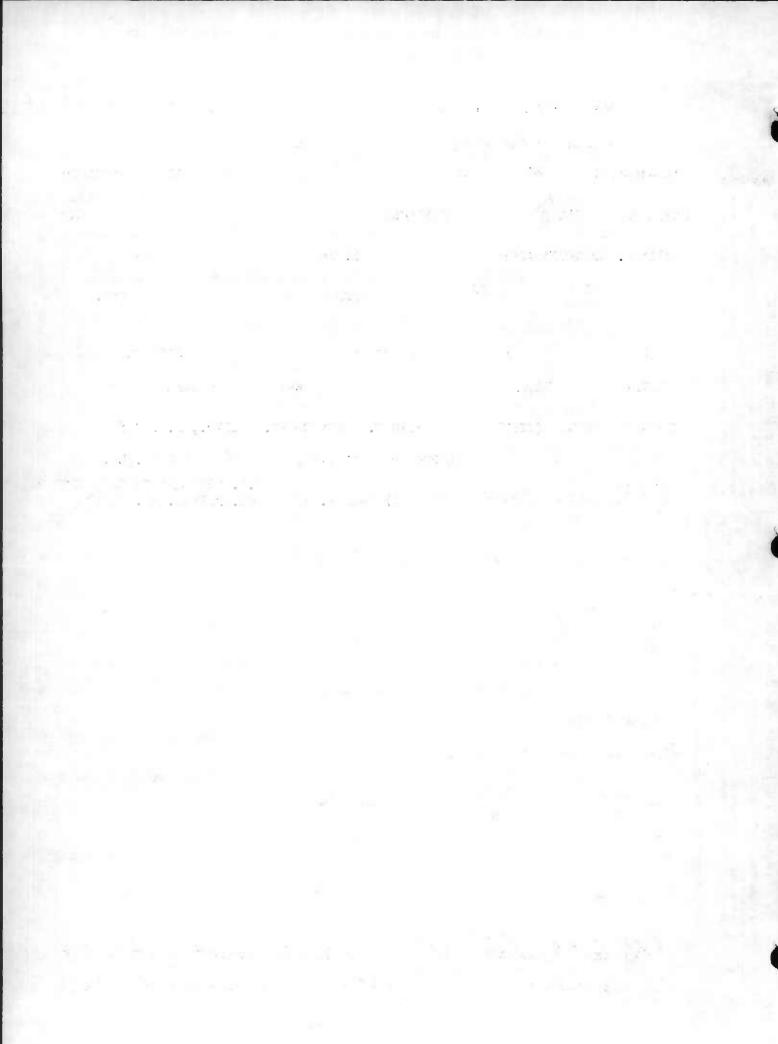
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

5 Pending

investigation

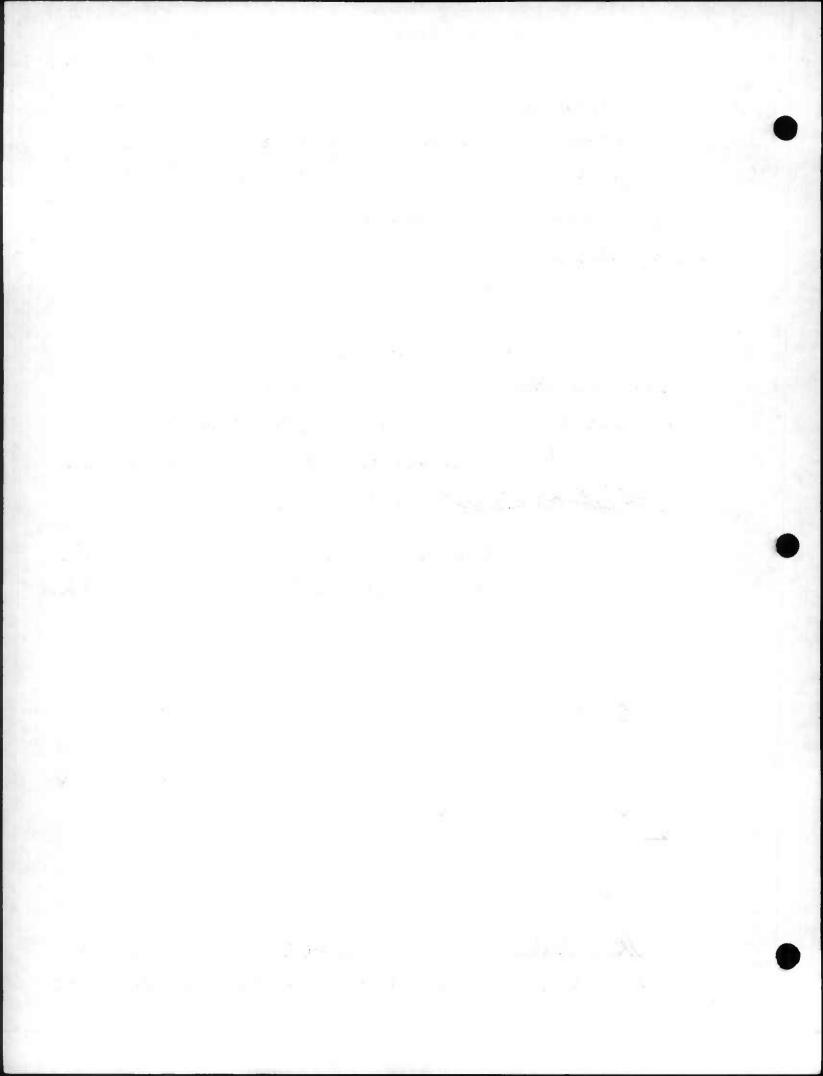
6 Could not be





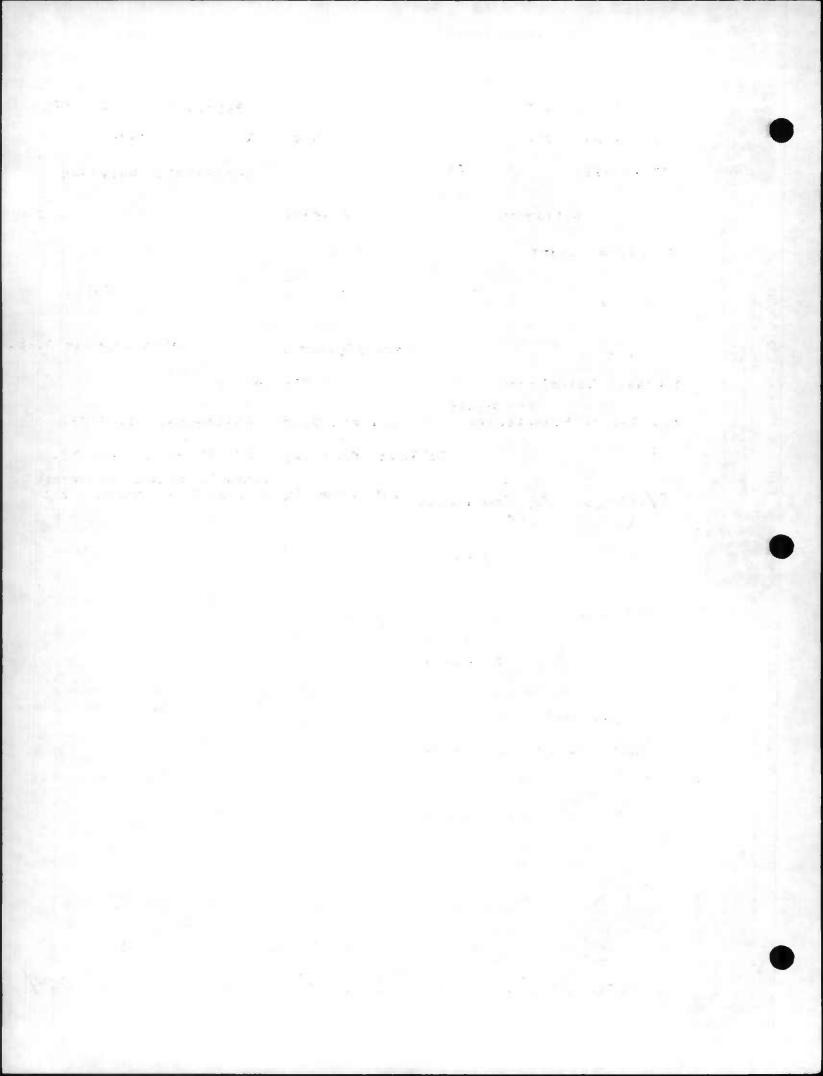
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/Medic		Maria H. Bula			Month Jun	Day 29	1998	1:12 PM				
/weun Examir		4e. Facility Name (If not institution, gi					4	o. City, Town, or	Location of Death			1.12 11
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Funeral Director			Sex 7. A 1 M 2 X F	ge (In yrs.	last birthday) 4 Yrs.	If Under 1 Months	Year Days	if Under 24 Hr Hours Mir		h y. Year) 3,1914	9. Birthple Counti UKRA	ace (State or Foreig ry) INE
ingowning restrictions after death with the maryland ther then "natural", or items 23a or 28a-1 show int, are Medical Examener mant by hotified at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10	d. Inside City Limit
	to	MD. HOWARD			COLUM	IBIA						1 ☐ Yes 2 ☐ W
	Director	10e. Street end Number				10f. Zip C	ode			10g. Citizen of	What Counti	ry?
	al [	6129 ENCOUNTER ROW 21045						15		U.S.A		
olical Examiner in	by Funeral	11. Marital Status  1 ☐ Never Merried 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 Yas XX If Yes, Give Year or Detes:	? No		Was Deceder t Yes, specify 1 ☐ Yes 2[		spenic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Rad Bla Specil	ca - America ck, White, e	tc.
200	Pa	15. Decedent's E	ducation		16a, Deced	dant's Usual	Occupa	tion		16b. Kind ot B	WHI usinass/Indu	
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other t		BOHDAN BULAWKA/SOI	V		2841 JESSUP RO			D, BOX				
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		4 □ Donation 5 □ Other (Speci		ST	. ANDRE				3/98 \$	BOUNDE	BROOK,	N.J.
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any injury or once.		(maleul)	X Laur	1	19	901 EA.	STEI	EN AVENU	IE, BALTIN	ORE, MD.	2123	1
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g physician end es the burial-transit	늘	Sequentially list conditions.  Dua to (or es a consequenca of):										71
	Exan	Sequentially list conditions	b		ation	neuce of):	foor	(				2 hours
	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying	b		ation	of	Food					2 hours
		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Dua to (d	or es a conseq	uenca of):	Food	(				2 hours
	edicai	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b	Dua to (d	ation	uenca of):	Cox	(				2 hours
	edicai	that initiated events	b	Dua to (d	or es a conseq	uenca of):	Food					2 hours
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	Physician/Medical	resulting in death) Lest		Dua to (d	or es a consequent	uenca of):		n in Part I.	23b. Did 1	-		A hours
	by Physician/Medical	Part tl. Other significent conditions		Dua to (d	or es a consequent	uenca of):		n in Part I.	1 □ ¹		3 ☐ Probe	
	by Physician/Medical	Part tl. Other significent conditions		Dua to (d	or es a consequent	uenca of):		n in Part I.	1 🗆 1	Yes 2 No an autopsy med?	3 Probe	e autopsy tindings lable prior to pletion of cause aath?
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Mary C. Bradley 8:00pm 28, 1998 August /Medical 4a Facility Name (If not institution, giva straet end number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 11 Galahad Court Baltimore Rosedale If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 75 Yrs 8-25-1923 219-16-3794 Director Maryland Usual Residence of Decedent with the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumstic event, the Macical Examiner must be notified at MD Baltimore Rosedale 1 Yas 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 IISA 11 Galahad Court Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed withIn 72 hours efter 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 N Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hosp. Transcriptionist 12th 18. Mother's Nama (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Haaith and Mentel Hant: if item 27 is marked oth jury or other trsumatic even Min Kessler Benjamin Meinzinger 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Friend Mr. Daniel Franckewitz Galahad Court, Baltimore, Md. 21237 Baltimore, 20b. Place of Disposition (Neme of 20c. Locetion - City or Town, Stata 20a. Method of Disposition Date netery, crematory or other plece) 1 ■Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of Important: If any Injury or once. 9/1/98 Baltimore, Md. 0aklawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Hm 21. Signature of Funeral Service License 263 S. Conkling St., Baltimore, Maryland 21224 annex 23a. Part1. It has the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Mis Driftymia **Examiner** Due to (or as a consequence of): Examiner physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be exect BICED GI P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 88 for use as Circhbot signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? ANTENIOVERON MARRANTE 24a. Was an autopsy Completed peen page 2 has PolyPI RACTAL 1 Yas 2000 1 ☐ Yas 2 ☐ No certificata Physician: 25. Was case referred to medicel exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this fumeral 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Attending 5 Pending 1/8 Natural I br Attendin after death. Director: An 1 Yas 2 No 2 Accidant investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) B 4 Homicide Dura 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Data signed (Month, Dey, Year) 29b. Signature and the of certifier 29c. License number 8.31 24276 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date (Month) State recen \* Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** William August 30 1998 Burke Sherman 8:26AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Johns Hopkins Bayview Baltimore Na 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Dey, Year) 5. Social Security Number Birthplace (Stele or Foreign Country) **Funeral** 1 M 2 □ F Deys 68 Yrs. Director 218-26-1477 April 6 30 Pittsburg, PA Usual Residence of Decedent with the Maryland permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show wall highly or other treumatic event, the Medical Example Figure Fruit to motified at Sale. 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland
10e. Street end Nu NA Baltimore 10e. Street end Number 10g. Citizan of Whet Country? 10f. Zip Coda 6422 21224 Bushey Street U.S. of America 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2□No If Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Supervisor Construction 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Sherman Burke Clara 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Wanda L. Burke (Wife) Bushey St. Baltimore, Md. 21224 6422 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Donetion 5 Other (Specify) APRISON Forest 21. Signeture of Funeral Service License W. Dabrowski-Chojnacki F.H.'s P.A. 1005 Dundalk Ave. Balto., Md.
ause, or complications they caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest,

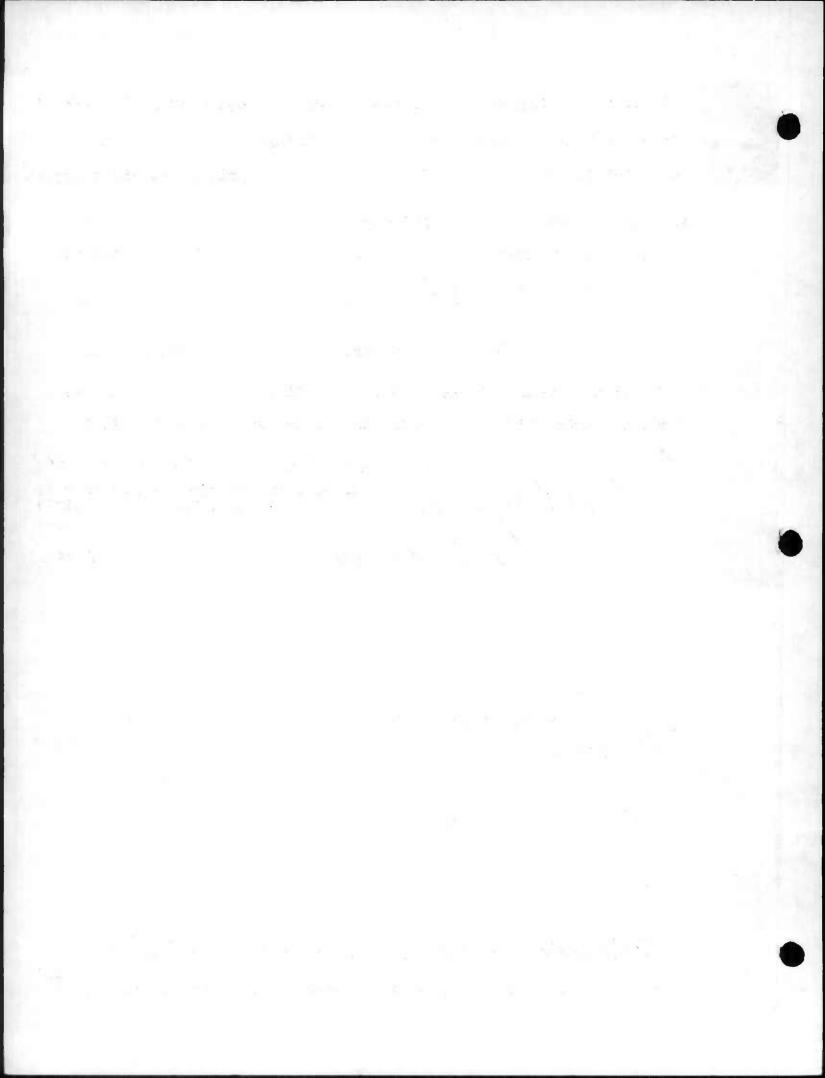
Agree. List only one cause of each line. 21224 **Physician** /Medical Immediete Cause (Final 10 405 disease or condition rasulting in deeth) Examiner physician end the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) P.O. F Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? this certificete 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physicien:
 24 hours effer death.
 Funeral Director: After this certifice etely filled in by the funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Manner of Daath 28c. Injury et Work? 28b. Time of 28d. Dascribe how injury occurred 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerei 15 Certifying Physicien: To tha best of my knowledga, daeth occurred at the time, date end pleca, end due to the cause(s) end mannar es steted.
2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, daath occurred at tha tima, data and placa, end due to the cause(s) end menner stetad. Medicai 29a. Certifler completely 29c. License number 29b. Signeture title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Marc Shiffman MD 2809 Boston St. Tindeco Health Center Balto., Md. 31. Dete filed (Month, Day, Year)
SEP 1 1998

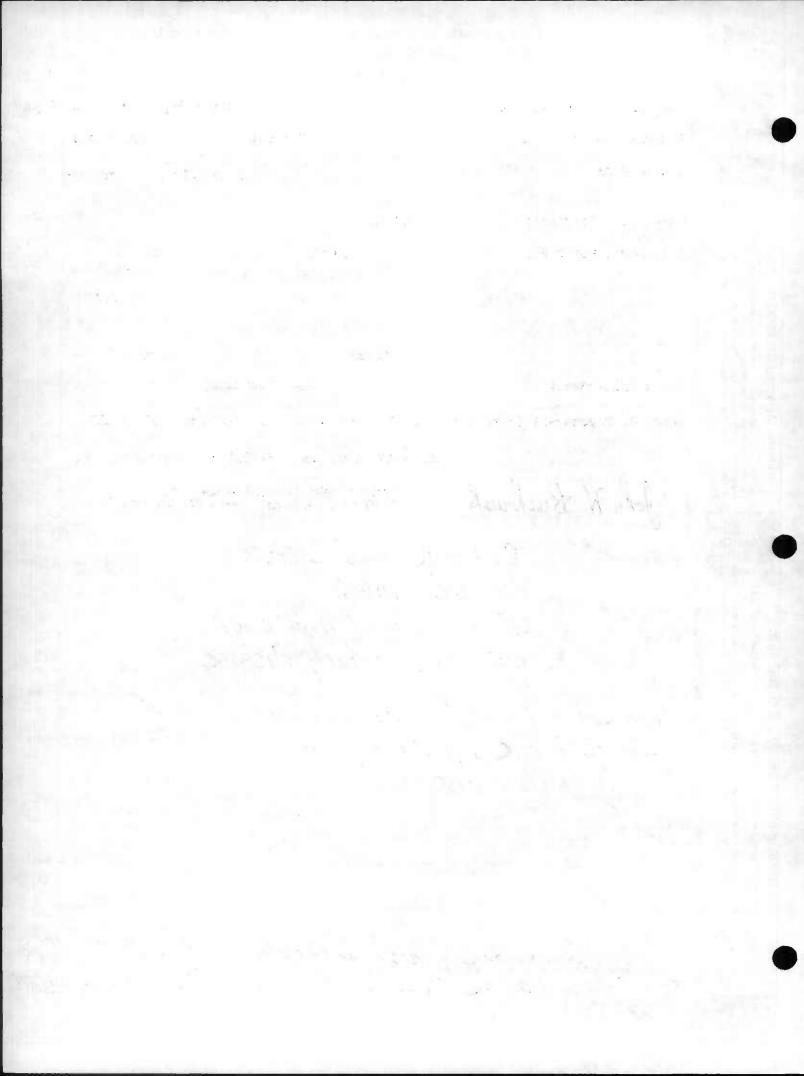
32. Registrer's Signature, Joseph January Jan

30. Name end eddrass of person who complated cause of deeth (Item 23e) (Type, Print)

21224



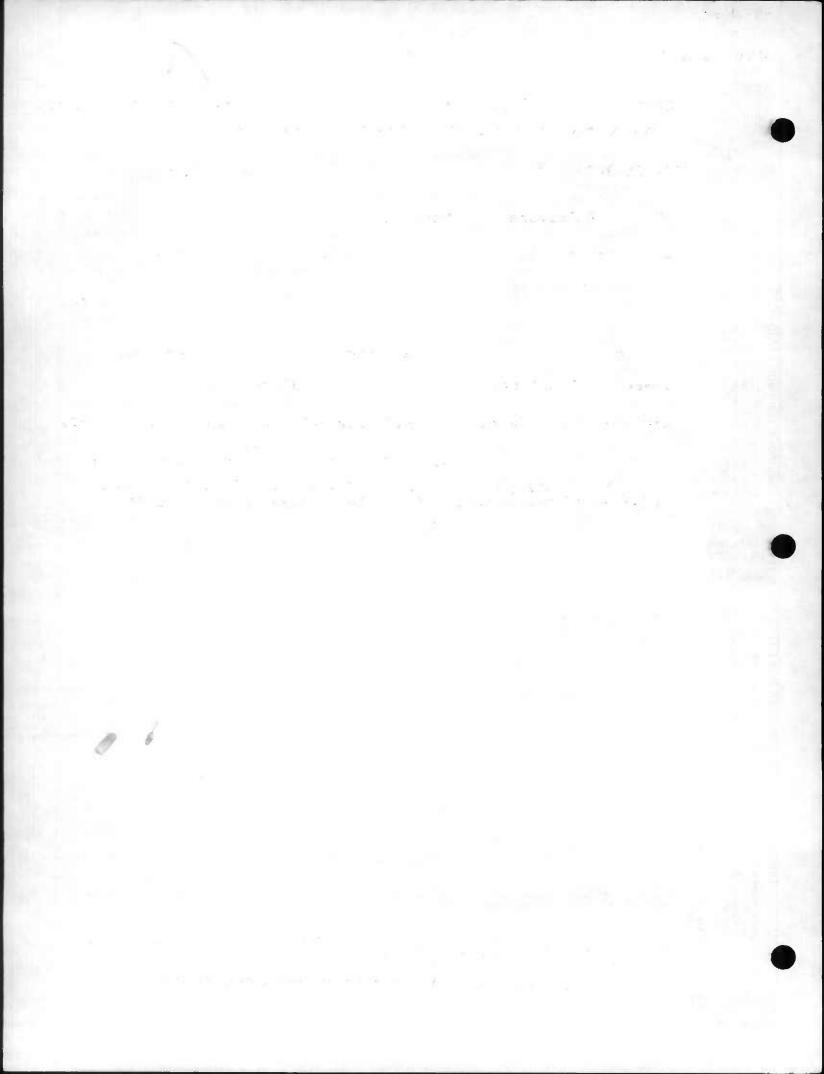
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Physician /Medical	Eleanor Rose Brzez	enski		August	25, 199	98 12:50 pm						
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Funeral Director	5. Social Security Number 6. S 216 36 5704	ex 7. Aga (In 83	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		Year)	9. Birthplaca (Stata or Foraign Country) Marvland				
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s 234			5-11C 40.1			(Seesity Vesser No.		- Amarican Indian,				
21215-0020 d within 72 hours after deeth with the Mejane. If then "natural", or frems 23e or 28e1 e. In Medical Examiner must be notified.	11. Marital Status  1 Navar Marriad 2 Married  3 Widowed 4 Divorced	12. Was Dacedent Evar Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas:		f Yas, specify Cuba 1 ☐ Yas 2 ☑ No	Specify:	(Spacity Yas or No- erto Rican, atc.)	Black,	White White				
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Balting Page Page Page Page Page Page Page Pag	4 Donetion 5 Other (Specify					20/1000	Dalcinoi	e, ra.				
Balti permit. Departm importa any infu	22. Nama and Addrass of Facility  Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221											
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Market 18	1/00/5//	10ml no	~ 11/1	11)4	5766	6	ugust	25 1998				
	30. Name and address of person who co	complated causa of death	(Itam 23a) (Type,	Print)	1	7/	0	11:				
-11111111	Tom Edmona	50N MD	9105	FRANKI	IN SQ	ugre L	or pal	timore MD2123				
State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's S	Signature	now M. I	U							



EDWARD BLUNT JR

State of Maryland / Department of Health and Mental Hygiene 9 9 5 5 9 8

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Maryland 21215-0020	led within 72 ho hygiene. Nor than "nature ht, the Medical Completed	pieren	15. Decedent's Ed (Specify only highest gre Elamantary/Secondary (0-12)	Sucetion de completed) College (1-4or 5+)	16e. Deceda (Give k life. D	ant's Us kind of w	uel Occupation ork done during mo use retired)	ost of worki	16b. Kind of Bus		usiness/Ind	ustry
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m)	and m 27 her tr		Marlene Blunt	/wife			ornwall	Rd		imore,		
Baltimore,	Page ment of ant: If I	2	20a. Mathod of Disposition  1 ☐ Burlal 2 【XCremetion 3 ☐  4 ☐ Donetion 5 ☐ Other (Specify	Removel from Stete	Plece of Dispos cemetery, cram etro C	atory or	other plece)	A	ug 31 1998	20c. Location		
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x 68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be dateched for use as the buriel-transit completed by Physician/Medical Examines.		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury hat initiated avants rasulting in daeth) Last	c	(or es e consequ							
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о. О.	be de ched	F	Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert I.						23b. Did tobacco use contribute to the cause of death			the cause of death?
	es that the death ce igned by the ettand be dateched for us.	3	ATHEROSCLEROTIC CAR	DIOVASCULAR DISE	ASE	-			10	Yes 2,EQ,No		ably 4 ☐ Unknown
Division of Vital Records,	The law require cate has been signed a pege 2 should be Completed								perfe	en eutopsy ormed?	eve	ore eutopsy findings bilable prior to appletion of cause deeth?
<u></u>	certificate rector, peg	3							1,23	Yes 2□No	12	Yes 2□ No
5	Ician: certific rector	3 2	25. Was casa rafarrad to medicel examiner?	Hospital:	<b>11</b> 7		Other		(Check only			
ō	Physic this coral direction of the coral dire		XXYes 2 No 27. Manner of Deeth	1 L Inpatient 22	28b. Tima of	3□ □	OA   4UI			how Injury occur		)
0	ding th. Afta		1 ☐ Naturel 5 ☐ Panding investigation	28e. Dete of Injury (Month, Dey Year) UNKNOWN	tnjury UNKNOWN	М	28c. Injury et Work? 1 ☐ Yes 2 [					
DIVISI	To the Hospital or Attending Physician: The I within 24 hours effer death.  To the Funeral Director: Attar this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		3 ☐ Suicide 6 ☑ Could not be datarmined	building, atc. (Spec	home, farm, stra		ry, office		UNKNOWN  28f. Location (Streat and Number or Rurel Route Numb City or Town, Stata)  UNKNOWN			Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	2		ysician: To the best of my kn niner: On the besis of examinand manner stated.								
	vithin o the		29b. Signeture end titla of certifier			2:	c. License number	r		29d. Date signe	d (Month, L	Dey, Year)
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		3	0. Nama and addrass of person who	Radentz,			treet, Ba	ltimo	re. Ma	rvland 2	21201	
	State		11. Dete fite (Meth. Dev. Year)	82 Registrar Sign		loc	das		,	aft.		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death **Physician** Mildred M. Curley 28, 1998 8:50 A. M. August /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cromwell Center - Genesis Eldercare Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mouth Days Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) **Funeral** 1 M 2 X F 219-32-6533 Director May 10, 1914 Maryland Usuel Residence of Decedent 10a. Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23e or 3605 Bonview Avenue 21213 U. S. A. Funeral death Itema 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married neturel, or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 □ Divorcad White Year or Dates Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be I Department of Health end Mental I Important: If Item 27 is merked of any injury or other traumatic eve George C. Fou 2 Margaret Lotz 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 8405 Hallmark Circle, Baltimore, Maryland 21234 Marilyn Ayd (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Most Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 8/31/98 Baltimore, Maryland 22. Name and Address of Fecility Schimunek Funeral Home Inc. 21. Signature of Fungral Service Licensee 3331 Brehms Lane, Baltimore, Maryland 21213 2 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only one ceuse on each line. 23a/ Part1. Enter the diseas Approximete Intervel Between Physician Onset end Death Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): requires that the death certificate be ex Box 68760. the Due to (or es e consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 3 Probably 1 ☐ Yes 2 ☐ No Records, þ 24b. Were eutopsy findings eveileble prior to Completed 24a. Wes en eutopsy performed' completion of cause of deeth? The law pege 2 s 1 ☐ Yes 2 KNo certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To /s after Ge... this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide filled within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifies. 041901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rich K. Mirta MD, BOUTE Dorsharn Park way, Paltimore, WM 21214 31. Deterilled (Month, Day, Yeer) 32. Registrer's Signatur State SEP 0 1 1998 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Dete of Death 3. Time of Deeth Month sabo AUGUST 11:00 A.M. 31 4a. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth GENESIS ELDERCARF AA CO SEVERNA PARK 8. Dale of Birth (Month, Day, Yeer) Country) SET (MARY LAND) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign 1 M 2 F Months Deys Hours 212 .10 7814 80 Yrs. Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ANNE ARUNDEL SEVERNA PARK 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 202 NEWPORT DRIVE 21146 U.S.A. 12. Wes Decedenl Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Yeer or Detes: 11 Maritel Stelus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER PAPER COMPANY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) CHARLES HARTLOVE IRENE WROTEN 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) LINDA RUSSO - DAUGHTER 202 NEWPORT DRIVE, SEVERNA PARK, MD 21146 20e. Method of Disposition \*\*Communication 3 | Removation 4 | Donetion 5 | Other (Specify) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete GLEN HAVEN MEMORIAL PK. 9/3/98 GLEN BURNIE. MD Signature of Purieral Service Licens RAYMOND C. FINK FUNERAL HOME OF GLEN BURNIE Tregow 426 CRAIN HWY., S.W, GLEN BURNIE, MD 21061 KELLY GREGORY FINK e, or complections that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, but only one cause on each line. Approximete Intervel Between Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes en eutopsy performed?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

10a. State

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f ahow the Modical Examiner must be notified at

the Maryland

death

filed within 72 hours efter

permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If Illem 27 Is marked other than

traumatic evant.

6

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest Physician/Medical The law requires that the signed by t ð

pege 2 should Completed peen hes Be 10 To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral Certification:

certificate

this

Physician:

25. Was case referred to medical

1 Yes 2 No 27. Manner of Deeth 5 Pending

1 Neturel 2 Accident Investigation 6 Could not be determined 3 Suicide 4 Homloide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tyes 2 No

26. Plece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

1 ☐ Yes 2 ☐ No

1 Yes

Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end manner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner es steted.

29b. Signeture en

29c. License number

28c. Injury et Work?

State Registrar

Medical

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 3. Tima of Death 2. Data of Daath Day Yaa COPLAN BERTHA 27 1998 11:20 PM AUGUST 4b. City, Town, or Location of Daath 4a Fecility Name (If not institution, give street and number) 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Data of Birth (Month, Day, Yaar) SEPT. 25,1909 If Undar 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) Birthplace (Stata or Foraign Country) 10 M XX Months Days Hours Min 88 Yrs. 219-10-7080 Usual Rasidance of Decedant 10d. Insida City Limits 10a Stata 10b County 10c. City. Town or Location 1 XYas 2 No MD N/A BALTIMORE 10e. Straet end Number 10f. Zip Code 10g. Citizan of What Country? 7111 PARK HEIGHTS AVE. #607 21215 U.S.A. 12. Was Decedant Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No It Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14 Race - Amarican Indian Bleck, Whita, etc. 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 X No Specify: 3 Widowed 4 □ Divorced WHITE 15. Decadant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Eiamentary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) BARNEY ABRAMS EVA GOLDSCHEIDER 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) HELENE PENN (DAUGHTER) 10 EAST LEE ST. #2600 BALTIMORE, MD 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 Buriai 2 ☐ Cremation 3 ☐ Ramovai trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) 8/30/98 BETH TFILOH CEMETERY BALTIMORE, MD 22. Nama and Addrass of Facility 21. Signature of Funaral Sarvica Line SOL LEVINSON & BROS., INC. 48900 REISTERSTOWN ROAD insul PIKESVILLE, MD 21208 Do not anter tha moda of dying, such es cardiac or respiratory arrast, 23a. Part1. Enter tha diseese, or complications that caused me disease, or haart tailura. List only ona causa on aach line Approximeta Intarval Batween Onsat and Death Immadiata Causa (Final disaasa or condition rasulting in death) PANCREATITIS 24 DAYS Due to (or as a consequanca ot): 24 DAYS CHOLELITHIASIS Sequantially list conditions, if eny, leading to immadiata causa. Enter Undarfying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequence ot): 24 DAYS DEHYORATION Due to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24b. Ware eutopsy tindings available prior to 24a. Was an eutopsy performed? ANEMIA completion of ceusa of death? 2 X No 1 ☐ Yas 2 ☐ No 25. Was cesa reterred to medical axaminer? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1 Nonpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima ot 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending invastigation 1 🗌 Yes 2 No 2 Accidant 6 ☐ Could not be datarmined 3 ☐ Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

**Examiner** Division of Vital Records. P.O. Box 68760.

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

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Examiner

Physician/Medical

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Certification:

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4 Homicida

(Check only one)

29a. Cartifian

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Madical Examiner mans to notified at

nd Mantal Hygiene.

important: If item 27 is a any injury or other terms

**Physician** /Medical

physician and the bunal-transit

attending p

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After

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72 hours efter

Pages 1 end 2 should be

OPLAN, BERTHA

lew requires that the death certificete be axecuted The Attending Physicien: death. D. A. Herbien or A. In 24 from a Orector.

State Registrar 29b. Signatura and title of certifier

29c. Licansa number 00053430

STREET

12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

29d. Data signed (Month, Day, Year) 1998 AUGUST 28

40

21204

BALTZMORE

30. Name and addrass of person who completed causa of daath (Itam 23a) (Type, Print)

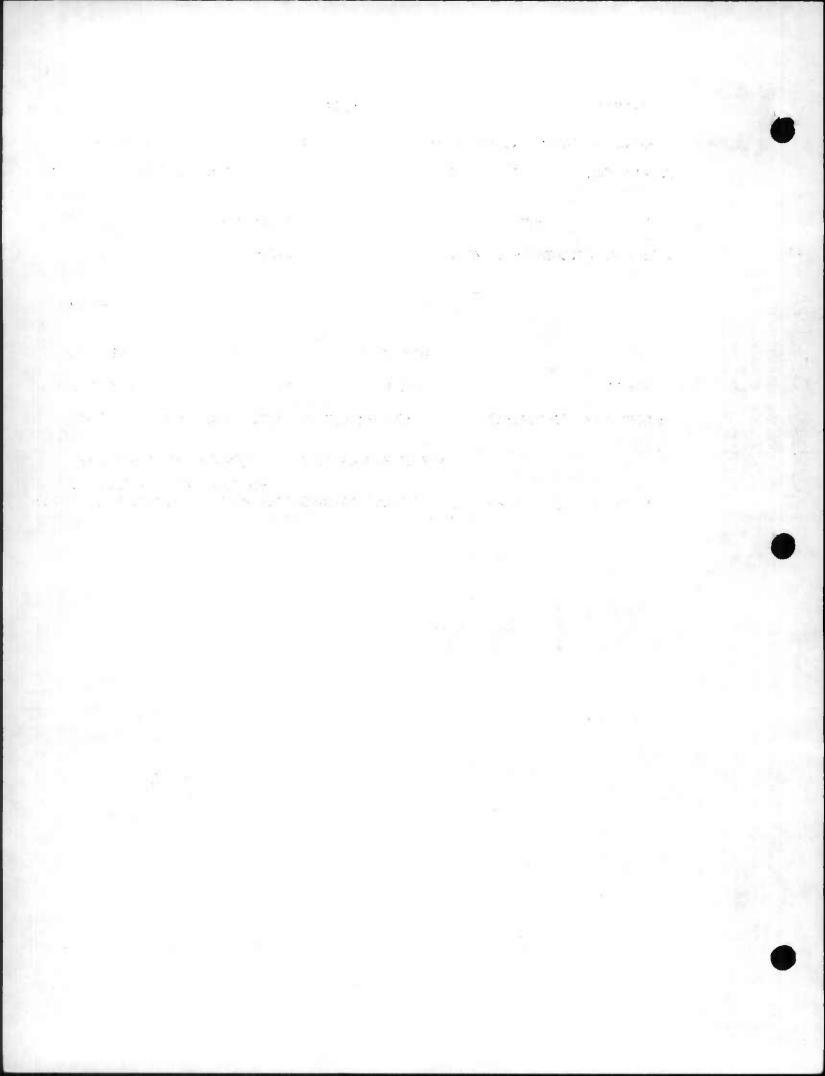
6701 NORTH GBM (

CHARLES

CHAN FRED 31. Data tiled (Month, Day, Year)

SEP 1 1998 32. Ragistrar's Signature

14.0.



	JAMES LI		DY CARTER ITEMS: #2  1. Decedent's Name (First, Middle, L		, 28A-F	Oen	ilicate of	Dealit	2. Dete of Dee			3. Time of Death	
	Physicia	n	JAMES LERG		FR				Month AUGUST	Dey	Yeer 98	0931 AM	
)	/Medica Examine		4e Fecility Neme (If not institution, grade 4941 DENMORE A	ve street and number)				4b. City, Town, o	Location of Deeth	4c. County			
	Funeral Director		5. Sociel Security Number 6. 214-72-8495 Usuel Residence of Decedent	Sex 1) M 2□ F 7. Aq 4	ge (In yrs. Ia 1	st birthday) Yrs.	If Under 1 Yes		8. Dete of Birth (Month, Dey MARCH	21,1957	9. Birthple Count BAL T	ece (State or Foreign (N) IMORE, MD.	
	within 72 hours effer death with the Maryland ene. "naturel", or items 23a or 28e-f show the Madical Examiner must be notified at		10a. Stete 10b. County MARYLAND			Town or Loc					10	od. Inside City Limits 1   Yes 2   No	
			10e. Street end Number 10f. Zip Code							10g. Citizen of V	What Count	Iry?	
		a	4905 QUEENSBERRY				2121			USA			
020	within 72 hours efter death wene. ene. then "naturel", or items 23s. the Medical Examiner must be	by Funeral	11. Marital Status  1 ☒ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 V  If Yes, Give Year or Dates:	?		/as Decedent of Yes, specify Cu ☐ Yes 2 N		Specify Yes or No- rto Rican, etc.)		e - America ck, White, e ,: AFRO		
D-C12	n "natur	Completed	15. Decedent's E (Specify only highest gi	ade completed)	5.)	(Give k	ent's Usuel Occ ind of work don O NOT use reti	e during most of w	orking	16b. Kind of Bi	usiness/Ind	ustry	
77	d with	E	Elementery/Secondary (0-12)	College (1-4or	5+)	SANI	TATION	WORKS		BALTIM	ORE C	ITY	
yland	should be filed nd Mental Hygic marked other immits event, iii	10 Be	17. Fether's Neme (First, Middle, Las  EXPERT WILLI	AMS				EDIT		ER			
Baltimore, Maryland 21215-0020	1 end 2 s Heelth ar hm 27 is ther trau		19a. Informent's Name/Relationship  EDITH CARTER  20a. Method of Disposition	(Type, Print) 10THER	20b. Ple	3905		ERRY AVE	BALTIMO Date		YLAND	21215	
OE .	Pages net of int: if its iry or o		1 Donetion 5 ☐ Other (Spec				MEMORIA		8/25/98	ARBUTUS	, MD.		
Dall	pemit. Pag Department Important: I any Injury o		21. Signature of Funerel Service Licensee  LLOYD M ESTER  LLOYD M ESTER  1300 EUTAW PLACE, BAL								LAND	21217	
ì	Physician /Medical Examiner	Je .	23a. Pan1. Enter the disease or conshock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	e	NARCOT		CICATION	y. 1. g., 2001, 20 00.0.				Approximete Intervel Between Onset end Death	
'n	be executed ician end bunel-iransit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	b Due to (or es e consequence of):								
DOX DO/DO		20	Ceuse (Diseese or injury that initiated events resulting in deeth) Last	c	Due to (or e	es e consequ	ence of):						
	attend for us	Clan		ontributing to death but not resulting in the underlying cause given in Pert I.					ook Blda			Ab	
	that the duded by the	by Physician/Medi	Pert II. Other significent conditions	contributing to death t	out not result	ting in the un	derlying cause	given in Pert i.		obecco use co ∕es 2□ No	3 Prob	the cause of deeth?	
Division of Vital Records,	The law requires that the death certificate ate has been signed by the attending physpeq 2 should be deteched for use as the	Completed							24e. Wes o	en eutopsy rmed?	COL	ere eutopsy findings bilable prior to inpletion of cause deeth?	
<u> </u>	The late he pege	E							1784	es 2□No	1)%	Yes 2 No	
VIIC	Physician: rthis certific rel director,	a a	25. Was case referred to medical examiner?	Hospital:			_ (	Whor	eath (Check only o				
ס עס	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Mon: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28e. Date of Inju	ury 2	R/Outpatient 28b. Time of Injury OUND: 9:	28c. In	4 LI Nursing	28d. Describe h	Home 5 ☐ Residence 6 Ø Meher (Specify) SCENE  28d. Describe how injury occurred  UNKNOWN			
DIVIS	al or Attendi s after death. il Director: A ed in by the f	Certification:	3 ☐ Sulcide 6 🐔 Could not determined	building, et						28. Location (Street and Number or Rural Route Number, City or Town, Stefe) 4941 DENMORE AVE.			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29e. Certifier (Check only one)  1☐ Certifying P 2	nysician: To the best miner: On the besis o end manner st	of examinetic	ledge, deeth on end/or inve	occurred et the estigetion, in my	time, date end ple y opinion, deeth oc	ce, end due to the courred et the time, o	ceuse(s) end mo dete end placa,	enner es st end due to	ated. the ceuse(s)	
	To the vithin 2 To the comple		29b. Signeture end title of certifier	u, M	- D.			onse number	1	29d. Date signe AUGUST			
	5		30. Name epo eddress of person was	estane	deeth (Item :	23e) (Type, F 1 <b>Penn</b>	Street	, Baltim	ore, Mary	rland 21	201		
	State Registra	3	31. Dete filed (Mönth, Day, Yahr) SEP 1		ar's Signetu		. ,500	uls					

#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month August 28, 1998 4:00pm Emanue1 Dorn Raymond 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Manor Care - Towson Baltimore Towson 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Hours Min 1**℃** M 2□ F Days 214-14-4234 Aug 24, 1914 84 Maryland Usuel Residence of Deceden 10d Inside City Limits 10a State 10h Count 10c. City. Town or Location 1 ☐ Yes 2 X No Maryland Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21131 USA 14226 Phoenix Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indien, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grede completed) Collaga (1-4or 5+) Elamentary/Secondary (0-12) 08 n/a Lathe Operator Black & Decker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Cecilia Sherrer Benjamin John Dorn Harriet 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 14226 Phoenix Road, Phoenix, Maryland Hilda G. Dorn/Wife 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) 8/31/98 Westminster, Maryland St. John's Cemetery 21. Signature of Funeral Service Liceose 22. Name and Address of Fecility Lemmon Funeral Home Bryan W. Clary 10 W. Padonia Road, Timoniu 23a. Part. Enter the divises, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failura. List only one cause on each line. 10 W. Padonia Road, Timonium, MD 21093 Approximete Interval Between Onset and Daath tmmediata Causa (Final disease or condition resulting in death) 119 Due to (or as a consequence of): kinsons Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or Injury that initiated evants resulting in death) Last Due to (or es e consequence of) 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2XXVo 1 TYes 2 No

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Directo

Funeral

by

Completed

Be

**Funeral** 

Director

than "natural", or items 23s or the Medical Examiner must be a

Baltimore, Maryland 21215-0020

filed within

Hygiene.

Pages 1 and 2 should be till ment of Health and Mental H lant: If Item 27 is marked oth jury or other traumatic even

Department of

funeral death.

Division of Vital Records, P.O. Box 6876

24 hours after Funeral Dire letely filled in b Hospital To the Within 2

edical Physician/M þ Completed or Attending Physician: Be 10 Certification: ector: after

> State Registrar

edical

Part II. Other atgniftcant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. NIDDM, HTN/CHF, hypothyroidisa 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

(Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

21204

August 31, 1998

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

7825 York Road, Towson, MD Theodore Houk, M.D.

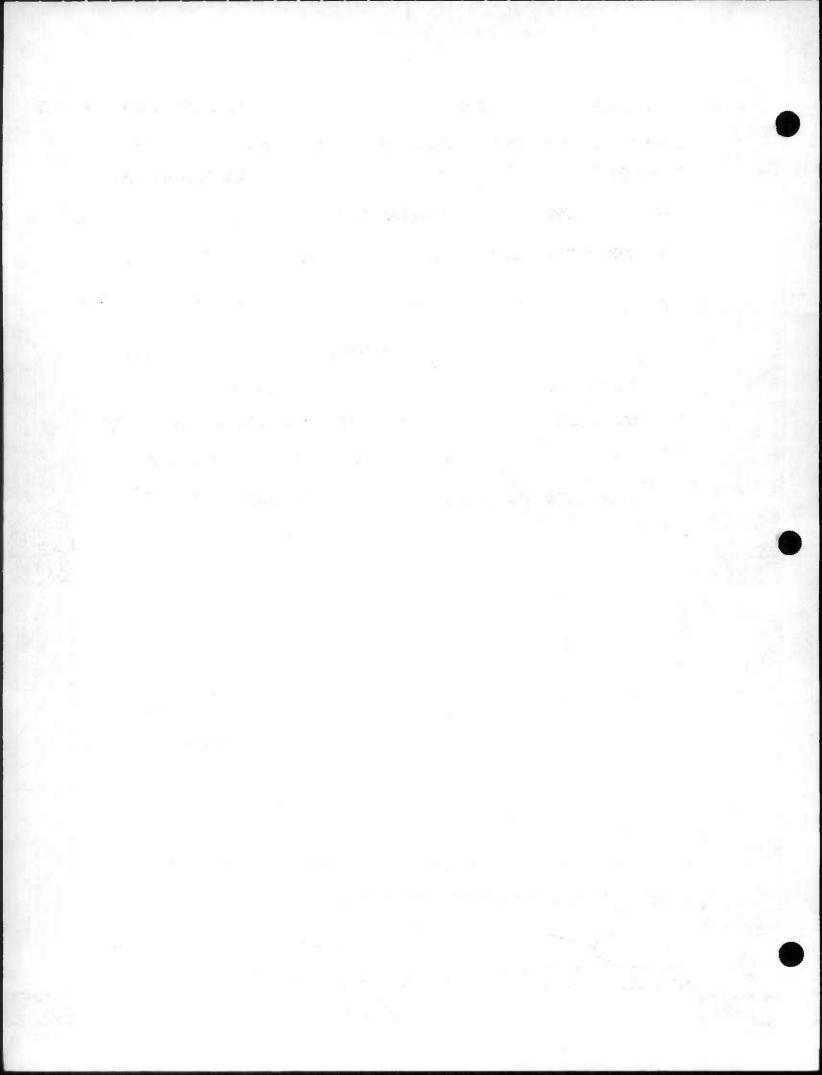
31. Date filed (Month, Day, Year) SEP 0 1 1998 32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, M.	iddle, Las	st)		C	ertitica	ite of	Death	2. Dete of D	Reg. No.		3. Time of Deeth	
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/Medi Examir		4e. Fecility Neme (If not Institution, give street end number)					-	4b. City. Town.	or Location of Dee		y of Deeth			
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Funeral		5. Sociel Security Number	6. Se			last birthda		er 1 Yea	BALTIM If Under 24 F	irs. 8. Dete of B	irth N		piece (Stete or Foreign	
Director		216-01-2836 Usuel Residence of Deceden		□ M 2□XF	9		Month	s Deys	Hours M	lin. (Month, L	2,1900	MARY	intry)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Phyglene. Important: if Item 27 is merked other than "naturel", or items 23e or 28e-f show airty faury or other traumatic event, if a Medical Examiner must be notified at ance.		10a. State 10b. Cou			10c. C	ty, Town or	Location						10d. Inside City Limits	
	ector	MD	N/A		В	ALTIM							1 Yes 2 No	
	Funeral Director	10e. Street end Number 902 SOUTH BA	YLIS	STREET			10f. 2	Ip Code 2'	1224		10g. Citizen of	What Cou		
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and Men is marks aumatic		19a. Informent's Neme/Reletionship (Type, Print)				19b. Me	iling Addre	ss (Stree	t end Number or	Rural Route Num	ber, City or Town	, Stete, Zij	p Code)	
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nent of He int: if iten iry or oth		20e. Method of Disposition	- 0 O	D		Plece of Dis	sposition (N	eme of other ple	ace)	Dete	20c. Location	- City or T	own, State	
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Departme Importan any injur		21. Signature of Funeral Serv	ice Licens	800					ess of Fecility	0,00,0	J -11.51			
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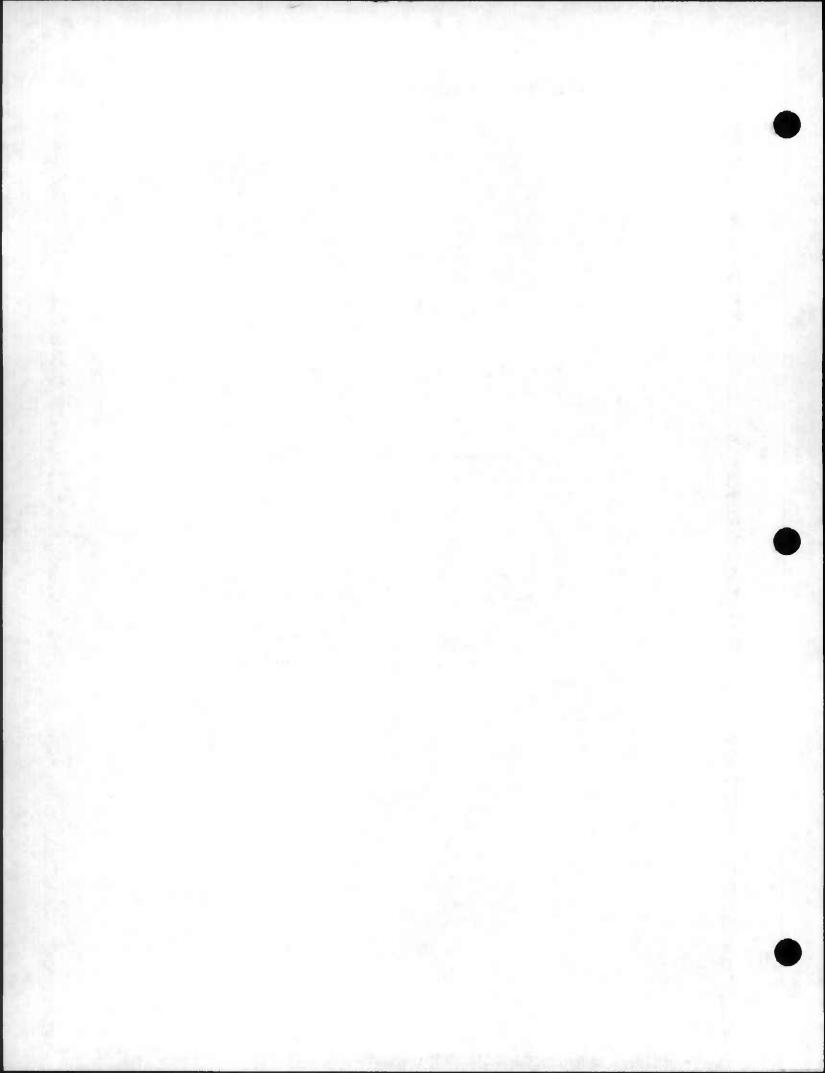
# VOID CERTIFICATE #

98-26605

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CERTIFICATE M

98 - 24838



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Agnes M. Draayer 29, 1998 9:27 pm August /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Baltimore Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Months Days Hours 1□ M 25 F 215 10 8352 A 82 Director Aug. 20, 1916 Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2 X No Essex Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 66 Stemmers Run Rd. 21221 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 8 Sales Clerk 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Howard Rose Dolan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William J. Draayer (Husband) 66 Stemmers Run Rd. Baltimore, Md. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State to 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 9/2/1998 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name end Address of Facility 21. Signa Funeral Service Licensee Bruzdzinski Funeral Home P.A. Durkouske 1407 Old Eastern Avenue Essex, Md. 21221 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, how, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** myocardial infarction /Medical Immediate Cause (Final hours disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician si the burial Physician/Medical Due to (or es e consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Lung Concer bengie be del A 24b. Were autopsy findings evellable prior to completion of cause of death? cirrhosis of Liver 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medicel Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical (Check only one)

29c. License number

N. Chales St. Bolto, md 2120x

29d. Date signed (Month, Day, Year)

Total

Box 68760

Division of Vital Records, P.O.

PaayER, UgnES

State Registrar 29b. Signature and tife of certifier

31. Date filed (Month, Day, Year)

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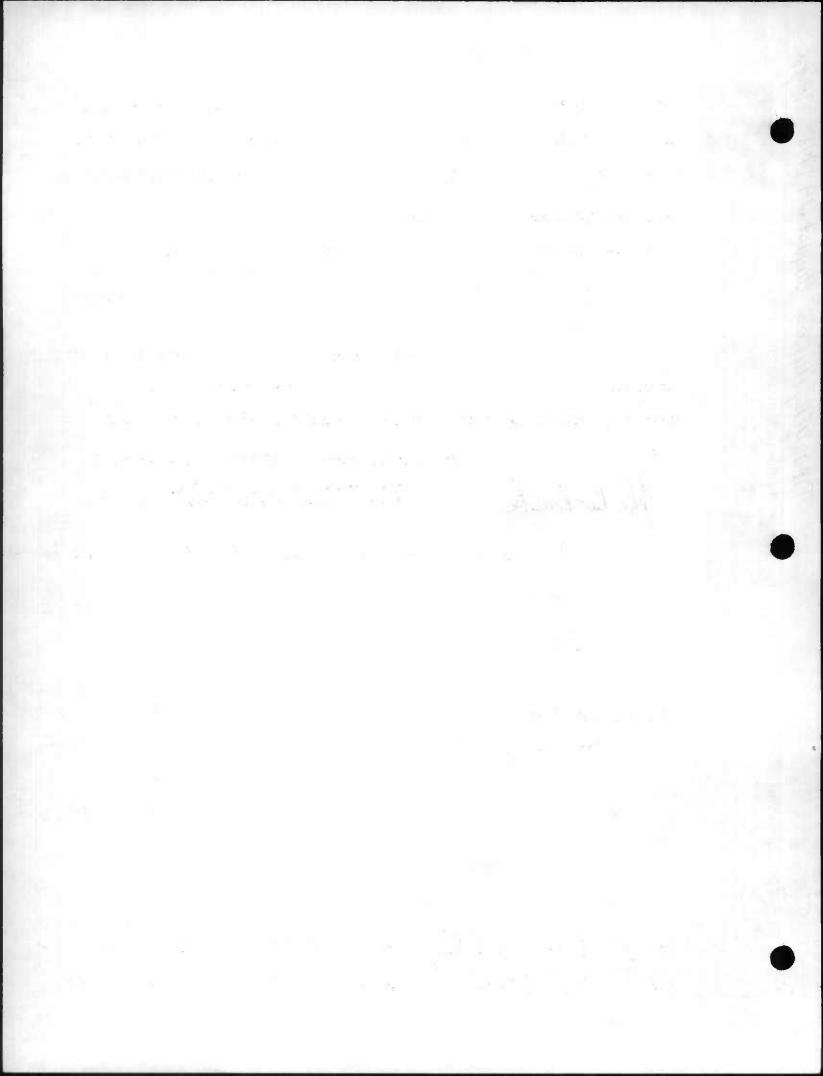
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

1 1998

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32. Registrar's Signature

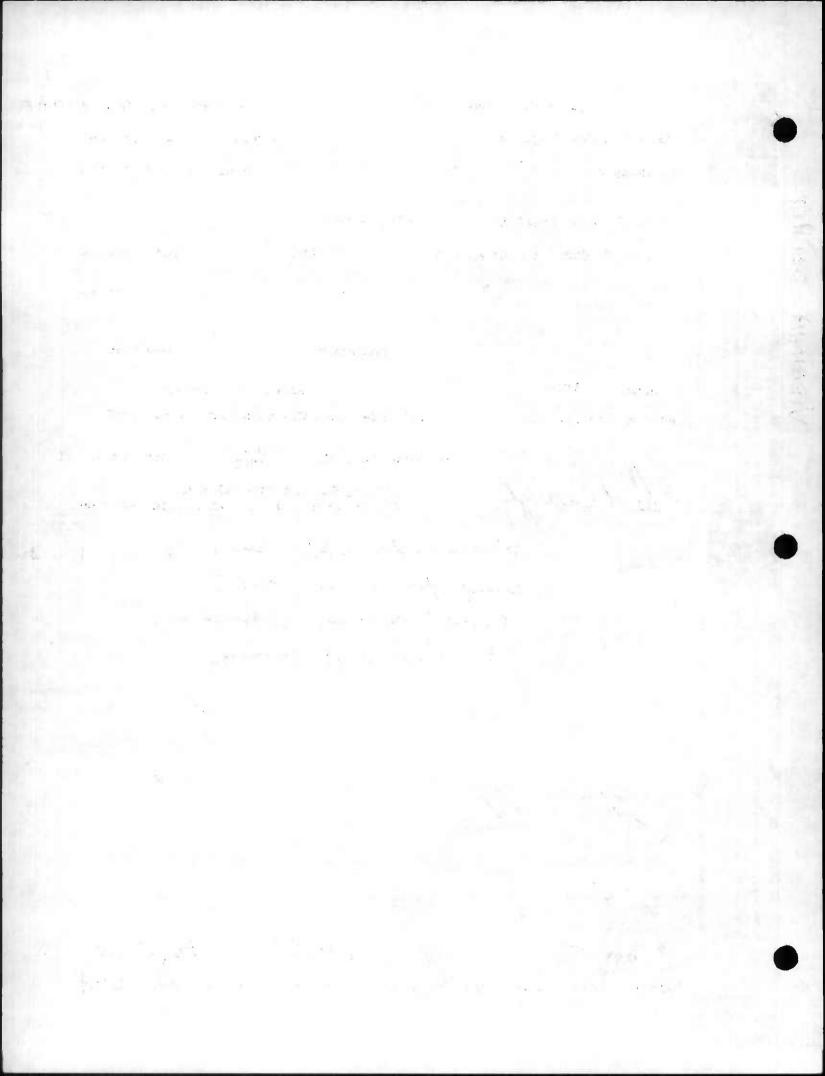


# VIRGINIA DREHER

		State of Maryland		ficate of		id Wientai i iy	Reg. No. 98	2	6607				
Physicia	1. Decedent's Name (First, Middle, L Virgini	ası) a M. Dreher			2. Date of Do	T Day	Yeer	3. Time of Death  X: DDA.m.					
' /Medica Examine	al for Facility Name (If not institution a				4b. City, Town	, or Location of Dea		of Death	Grace				
	North Arundel H	ospital			Glen B		Anne						
Funeral Director	216-18-4918	Sex 1□ M ★ 7. Age (In yrs. I		f Under 1 Yaar fonths Days		Hrs. 8. Date of Bi Min. (Month, D Aug. 1	rth ay. Year) 1, 1924	9. Birthplaca (Stata or Country) 1924 Maryland					
buel w	Usual Residenca of Decedent  10a. State 10b. County	10c. City	, Town or Locat	ion				10	d. Inside City Limits				
Mary Fed	Maryland Anne Arundel Glen Burnie												
or 28	Maryland Anne in 10e. Street and Number			10f. Zip Code			10g. Citizan of What Country?						
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urs e	11. Marital Status 1  Naver Married 2 Married 3  Widowed ◆∰Divorced	12. Was Decadent Ever in U, Armed Forces?  1 ☐ Yas ※☐ No If Yes, Give Yaar or Dates:	If Y	s Decedent of Fees, specify Cub	an, Maxican, F	n? (Specify Yas or N Puerto Rican, etc.)	or No- 14. Raca - American Indian, Black, Whita, etc.  Specify: White						
5-0 72 ho	15. Decedent's i	Education	16a. Deceden	t's Usual Occup d of work done NOT use retire	ation during most of	f workina	16b. Kind of Bu	usiness/Indi	ustry				
21215-0020 d within 72 hours ef piene. r then "natural", or tra Medical Exam	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retire			Own	Home					
d 2121 filed within Hygiene. fther then	6 17. Father's Name (First, Middle, Las					Name (First, Middle							
0 0 0	James Pot	ee			Mabe	1 B	ryant						
Mary d 2 shoul th and Me 7 is mark traumati	19a. Informant's Name/Relationship		19b. Mailing	Address (Street	and Number	or Rural Route Numi Glen Burn	er. City or Town.	State, Zip	Code)				
F - 01 A	Judy Smith/Daug		laca of Dispositi		.II way				Charles Charles				
Pages 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removel from Stata	ametery, cremate HAven	ory or other pla		ept. 1,	20c. Location - Glen						
Baltimore, permit. Pages 1 er Depertment of Hea important: If Item 2 any Injury or other	4 Donation 5 Other (Spec			ame and Addre		1998	GICH	Darm					
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	23a. Part1. Entar tha disaasa, or con shock, or heart failure. List only	nplications that causad the death	1. Do not enter t	Crain ha moda of dyi	Hwy . S	.E. Glen	Burnie, arrast,		.061 Approximate Intervel Between				
Physician	snock, or heart failure. List ont	y one cause on each line.	11		1	\			Onset and Death				
/Medical Examiner	Immediate Cause (Final disease or condition resulting In death)	Nov 2	new	a	U	ming	Can	ces	1 mont				
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60,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequenca of):  Due to (or as a consequenca of):												
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death certificate e ettending phys d for use es the	Part II. Other significant conditions			- 1									
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The The cate h						10	Yes 2 No	10	Yes 2□ No				
	25. Was case referred to medical examiner?	Hospital:	5D/O 4-4-4	26. Place of Death (Check only one)  3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
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DIVISION I or Attending after death. Director: After d in by the fune	27. Manny of Death 1 Natural 5 Pending investigati 2 Accident investigati 3 Sulcide 6 Could not determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
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Nithin Fo the comple	29b. Signature and title of cartifiar			29c. Licans	sa number		29d. Date signed (Month, Day, Year)						
	Borlow	Y	M	24	3977		Araus	28	1998				
10	30. Name and address of person who	completed ceuse of deeth (Item	23a) (Type, Pri	nt)	01	^	, ,		/ \				
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Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Katherine Theresa Emerson August 28, 1998 7:30 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | May 6, 1946 Rosedale Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 212 50 2701 52 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location r than "natural", or flama 23a or 28a-f show the Medical Examinar must be notified at 10d. toside City Limits 1 ☐ Yas 2 No Director Maryland Baltimore Middle River 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 9727 Conmar Rd. 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Mades one. Elementary/Secondary (0-12) College (1-4or 5+) Dental Assistant Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Henry Markley Catherine Lotz 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Emerson (Daughter) 9727 Conmar Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 8/31/1998 Baltimore, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Párt1. Enter the disaase, or complications that caused the death. Do not enter tha *mo*de of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Betwaan Onset and Death **Physician** Metastatic Adeno Un. Known /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pue Due to (or es a consequence of): physician s the burlai Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? ă 1 Yes 2 No 3 Probably 4 Unknown Compression à 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of deeth? Completed 1 Yes 2 No 1 Yes 20 No certificate 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) this. 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Ahac 5 Pending investigation A Hospital or Atten-24 hours after death. (Director: AP 1 Natural Attending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated. within 2 To the 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 200 D-38754. 08-31-98 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 404. BASTERN BLVD. MD - 21221. MALIKA WASBEM. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

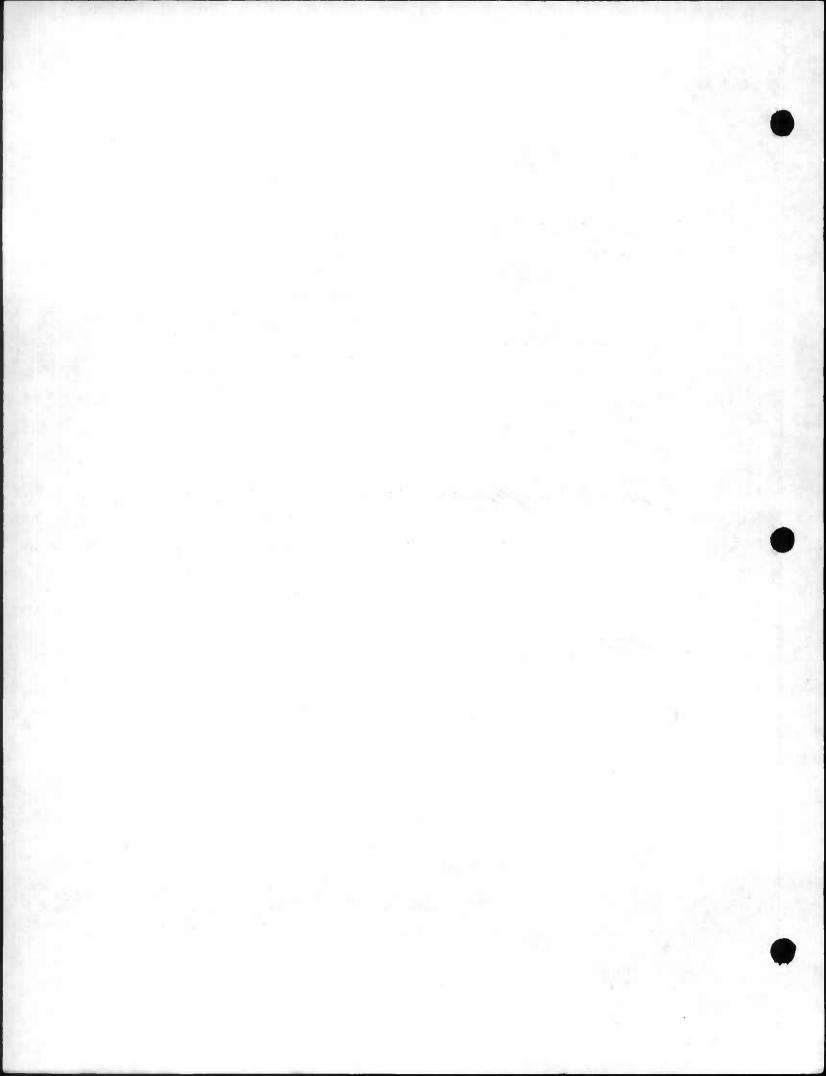
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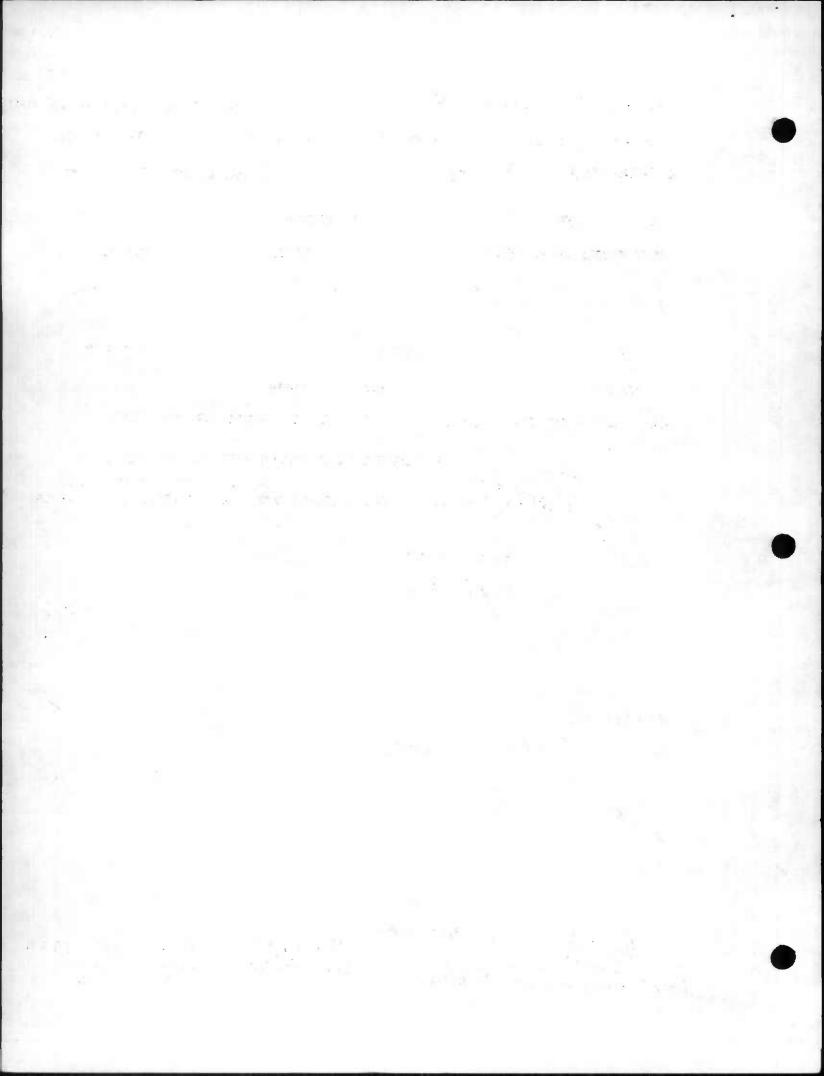
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permit. Pages Department of Important: If it any injury or o	21. Signature of Puneral Supres Cit	+10	22.14	ane and Address of Facility	SOL LEVI		OS., INC.
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	23a. Part1. Enter the disease, or or shock, or heart failure. List on	y one cause on each lin	the deeth. Do not enter to e.	ne mode of dying, such as ca	ardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
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**Funeral** 

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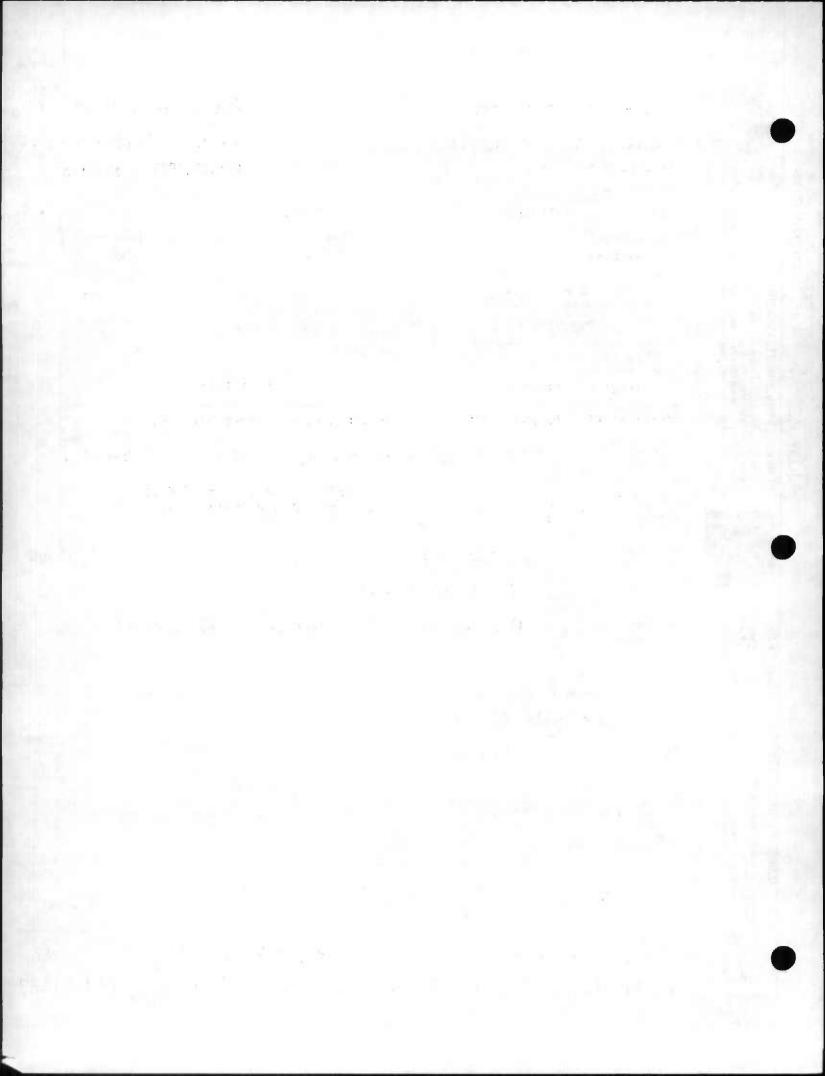
To the Hospies, within 24 hours after To the Funeral Dire

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Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month **Physician** August 1998 31 1235 a.M JAMES U. FITZSIMMONS /Medical 4c. County of Death 4b. City, Town, or Location of Quath 4e Fecility Nema (If not institution, give street end number) Examiner Rosedale Baltimore Franklin Square
5. Social Sacurity Number 6. Sax HOS pita If Undar 24 Hrs. 8. Data of Birth October 23, 19925 7. Aga (In yrs. last birthday) 72 Yrs. 9. Birthplaca (Stata or Foreign Months Deys Mary land 214-20-2062 10 M 20 F Hours Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d Insida City Limits Md. Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Counfry? 4 Hartman Ave. 21221 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1XXYas 2 ☐ No Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 Navar Marriad 2 X Married specify: White If Yas, Giva Yaar or Datas: 1 Yas 2 K No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Dacedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) Collega (1-4or 5+) Assembly Line GM 9th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) Alva Trimker James Fitzsimmons 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zio Coda) 19a. Informent's Name/Relationship (Type, Print) 4 Hartman Ave. Baltimore Md. 21221 Margaret Fitzsimmons / wife 20b. Placa of Disposition (Nama of cematary, crametory or othar placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Spacify) Holly Hill Cemetery 9/3/98 Baltimore Md. 22. Name and Addrass of Facility 21. Signatura of Funaral Sarvice Licanses Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 challenges on aach lina. Approximeta Intarval Batween Onsat and Daath Immadiata Causa (Final 7 days DSIS disaasa or condition resulting in death) nutrition Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Ceusa (Diseasa or Injury that initiated avants rasulting in daath) Last Dua to (or as e consequence of) Transitional Cell Cancer Metastatic Physician/Medicai Due to (or as e consequance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown eft above the Knee Completed by 24b. Wara autopsy findings eveilable prior fo 24a. Was an autopsy Ambutation complation of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case refarred to medical axaminar? 26. Placa of Daath (Check only one) Othar: 4 ☐ Nursing Home 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To 1 ☐ Yas 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding invastigation 1 Natural 1 Yes 2 No 2 Accident 3 Suicida 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Phyalcian: To the best of my knowledge, death occurred at tha tima, data end placa, and dua to the ceuse(s) end menner es stated.
2 Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data end place, end dua to the causa(s) end mannar statad. 29a. Certifier Medical (Check only one) 29b. Signatura and titla of cartifier 29c. License number 29d. Data signad (Month, Day, Yaar) #191700 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) FRANK 9000 Franklin Square Drive Baltimore DRChristing 31. Data filed (Month, Pay, Year) SEP 0 1 1998 32. Ragistrar's Signatura State Registrar

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State of Maryland / Department of Health and Mental Hygiene

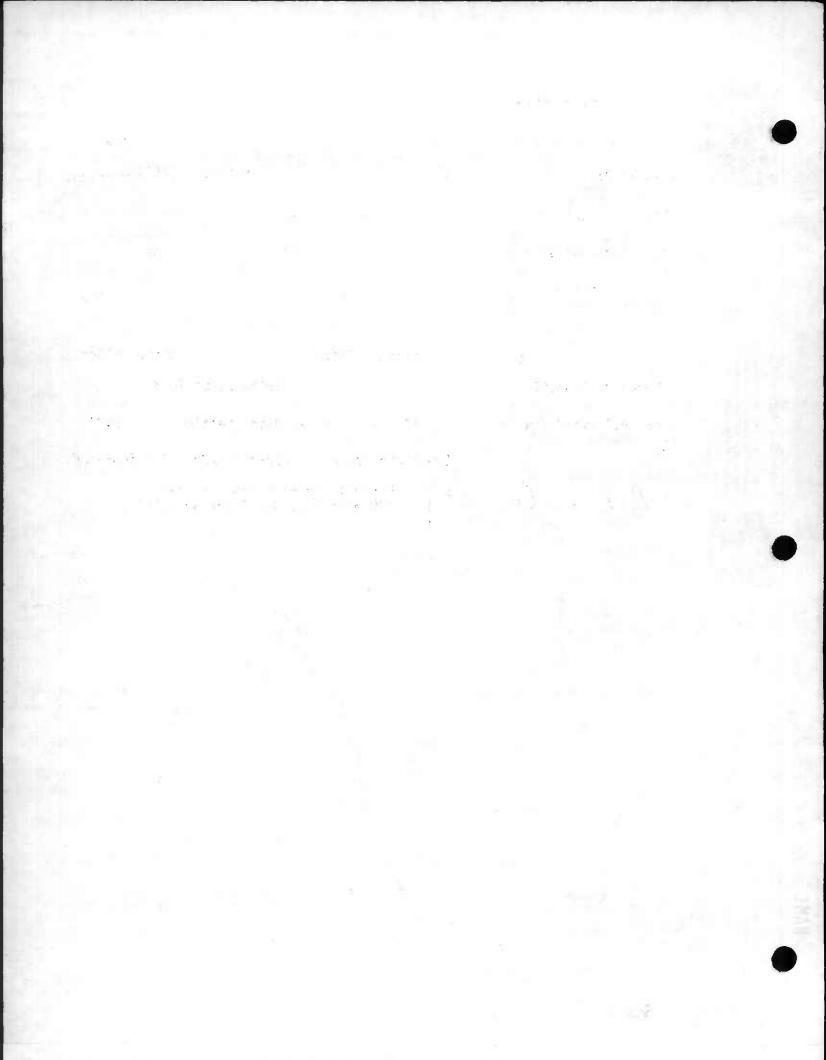
Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month LEROY A. GIFFORD **Physician** 17 AUG 29 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Baltimore, MD - 900 CATON AVE. ST AGNES HOSPITAL n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) Deys October 26, 1952 MAryland 1∭ M 2□ F Yrs 45 216-62-4422 Director Usual Residence of Decedent the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumstic event, ira Madical Examiner must be notified at Md. Baltimore Middle River 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 506 Middle River Road USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Police Officer State Police 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy B. Bennett Betty L. Gifford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traun Karen D. Gifford / wife 506 Middle River Road Baltimore Md. 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Memorial Gardens9/2/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Connelly Funeral Home of Essex Ogran 300 MAce AVe. Baltimore MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only the cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Final diseese or condition resulting in death) /Medical CARdiac Arrest 10 mints Examiner Due to (or as a consequence ot): 4 years. Examine CORONARY Artery Disease Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): as USB 23b. Did tobecco use contribute to the cause of death? Part II, Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown signed t by 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed been completion of ceuse of death? page 2 s has 1 ☐ Yes 2 No 1 Yes 2 No certificate 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Be Hospitel: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No To this funeral 28a. Date of Injury (Month, Day Year) 27, Menner of Deet 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ofter death Director: 28f. Location (Street and Number or Rurat Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Samer Krew M.D P11073 AU9. 29.1998 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) - ST AGNES HOSpital - 900 CATON AVE - Bultimore MD 21229 SAMIR KHEIRL 31. Date filed (Month, Day 1998) 32. Registrer's Signature State

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Registrar

GIFFORD,



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 30, 1998 5:00P.M. KATHERINE A. GROSS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson Hours Min. 8. Date of Birth (Month, Day, Year) 8 / 22 / 35 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2OXF Director 213-30-6608 63 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at 1 ☐ Yes 2X No BALTIMORE WOODLAWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? i Norma 23a 2 MT. BATTEN COURT T-421207 U.S. Funeral Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Status Black, Whita, atc. 1 Yes 2 No If Yes, Giva Year or Detas: 1 Never Married 2 Merned 8 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ₺ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 NURSE MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be and Mental HARRY SATTERFIELD 10 KATHERINE GWALTNEY 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau 2009. . Health JOANN BARNES (DAUGHTER) 17420 NURSERY COURT-MT. AIRY, MARYLAND altimore, 20b. Plece of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete B 1X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete ARBUTUS MEMORIAL PARK 9/4/98 ARBUTUS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ELIZABETH L. PHILLIPS, P.A. 21. Signature of Funeral Service Licenses ertor 1721-27 N. MONROE ST. - BALTIMORE, MARYLAND 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** ANOXIC ENCEPHALOPATHY DAYS /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es a consequence of): RESPIRATORY FAILURE DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): VENTRICULAR FIBRILLATION ARREST DAYS Physician/Medical Due to (or es e consequence of): DILATED CARDIOMYOPATHY P.O. Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY Records, à 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 Yas 2 No Division of Vital I or Attanding Physician: after death. Director: After this certific 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide \_ Delli / hours 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner stated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi edical 29b. Signature and title of certifier W 29c. License number 29d. Date signed (Month, Dey, Year) D31826 8-31-98 ricu m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD LINTHICUM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar BOBER S

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		Funeral Director
NAME: GARDNER, RAYMOND H.	Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.
		Physician /Medical

Physicia /Medic Examin

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	/IVI	sıcı ledic amin
	EX	amın
Division of Vital Records, P.O. Box 68760,	ospital or Attending Physician: The lew requires that the death certificate be executed house after the continues the continues of the continu	unes to disconsiste this certificate hes been signed by the attending physician end the strength of the streng

			Cer	tificate	e of	Death			Reg. No	).		
1. Decedent's Name (First, Middle, Las		7						2. Date of De	eath Da	ıv	Yeer	3. Time of D
Raymond Howard Gar	dner							August		199		6:50
4a Fecility Name (If not institution, give	street and numbe	r)			4	4b. City, To	wn, or L	ocation of Deat	h 4c	. County	of Death	
FORT HOWARD VA M	MEDICAL C	ENTER				FORT	HOW	ARD		BALT	TMOR	E
5. Social Security Number 6. Se	7. A	Age (In yrs. le		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	,	9. Birthpl Count	ece (State or F try)
217 09 2009	ØM 2□ F	86	Yrs.					March				yland
Usual Residence of Decedent  10a. State 10b. County		10c City	, Town or Loc	cation							10	od. Inside City
	.0			ssex								1 ☐ Yes 2
Maryland Baltimor	-		116	10f. Zip	Code				10a Ci	tizen of W	Vhat Count	Inv?
122 Alcock Rd.					221					JSA	mat count	uy:
	12. Was Deceder	at Ever in 116	2 12 14	1		lienenic Ori	ain? /Sn	ecify Yes or N			e - America	en Indian
11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces	\$?	of If	Yes, spec	ify Cube	an, Mexicen	, Puerto	Rican, etc.)			k, White, e	
3 Widowed 4 Divorced	If Yes, Give Yeer or Dates			☐ Yes 2	No 🌃 No	Specify:				Specify:	Whi	.te
15. Decedent's Ed		. 4444 7	16a Deced	ent's Usua	l Occup	etion			16b. K	(ind of Bu	siness/Ind	lustry
(Specify only highest gra-	de completed)		(Give I	kind of wor OO NOT us	k done	durina mos.	t of work	king				
Elementery/Secondery (0-12)	College (1-4o	r 5+)	Postr	nan					US	Post	al S	ervice
17. Father's Neme (First, Middle, Last)				-		18. Mothe	r's Nam	e (First, Middle	, Maider	2 Sumam	e)	
Howard E. Gardne	er					Mary	El El	len Obr	ien			
19a. Informant's Name/Relationship (7	ype, Print)	11100	19b. Mailin	g Address	(Street	and Numbe	er or Rui	ral Route Numb	per, City	or Town,	State, Zip	Code)
Thelma Gardner (Wi	fe)		122 2	Alcoc	k Ro	d. Bal	Ltim	ore, Mo	1. 21	1221		
20a. Method of Disposition		20b. PI	ace of Dispos	sition (Nam	e of	00)		Date	20c. L	ocation -	City or To	wn, State
1 Surial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specify			metery, crem lv Hil				38/2	9/1998	Balt	imor	e Co	. Md.
23. fail. Enter the disease, or composition, or heart failure. List only of mmediate Cause (Final disease or condition			PNEUMO									Interval Betwee Onset and De
disease or condition resulting in death)	a. ASPIRA		as a consequ									Z MOHU
	TIDTAIAE		CT INF		NAT.							3 month
Sequentially list conditions	b. UKLIWAY		as a consequ		NA .		_					3 IIDIIU
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury	CHICAN				T MOO	ATATYSE I	DT CT	NOTE:				SZEDA DO
that initiated events	c. CHRUNI		IRUCTI as e consequ		LMU	VARY	DISE	ASE			-	YEAR
resulting in deeth) Lest											i	
	d										1	
Part II. Other significant conditions co	entributing to death	but not resu	Iting In the un	nderlying ca	ause giv	/en in Part I		23b. Dtd	tobacco	o use con	ntribute to	the cause of
								1□	Yas :	2□ No	3 □ Prob	pably 40 U
								24a, Wa	s an auto	psy	ava	ere eutopsy fin ailable prior to
											of (	mpletion of cau death?
								10	Yes 2	2 No	10	Yes 2 N
25. Was cese referred to medicel						26. Place	of Dea	th (Check only	one)			
examiner? 1 Yes 27 No	Hospital: Inpa	itient 2 1	ER/Outpatien	t 3 DO	A Oth	ner: 4 🗆 Nu	ursing He	ome 5 Res	idence	8 Othe	er (Specify	1)
77. Menner of Death  1 X Natural 5 □ Pending	28e. Date of In	njury Day Year)	28b. Time of Injury	2	8c. Injui Wo	ry et		28d. Describe	how inju	ary occurr	ed	
2 ☐ Accident investigation		,,	,,	М		Yes 2	No					
3 ☐ Suicide 6 ☐ Could not be determined	200. Place of t	Injury - At ho	me, farm, stre	eet, factory	, office			28f. Location City or To			er or Rura	I Route Number
29a. Certifier (Check only one) Certifying Physics (Check only one)	rsician: To the besiner: On the basia and manner	of examinati	vledge, death ion and/or inv	occurred a restigetion,	at the tir in my c	me, date en opinion, dea	nd place, ith occur	and due to the rred at the time	e cause(s , date an	s) end me id place, a	nner as st and due to	ated. the ceuse(s)
9b. Signature and title of certifier	/	1		290	. Licens	se number			29d. Da	ate signed	d (Month,	Day, Year)
1 la sas tura	an	6de	ne		D	(7.)	P		5	1/27	19:	8
30. Name and address of person who d	completed cause of	f death (Item	23a) (Type. I	Print)	/ /	700	-			1-1	-1-1	
CAROLINA CUSTOD			ORIH P		RD.	FORT	HOW	IARD, M	210	052		
11. Date filed (Month Day, Year)	32. Regis	strer's Signat	3	8								
OEL 1 1936	1		N.	doa	cho	A.						

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Street Land Co. Alfada

Service Comment &

DOCUMENTS OF STREET

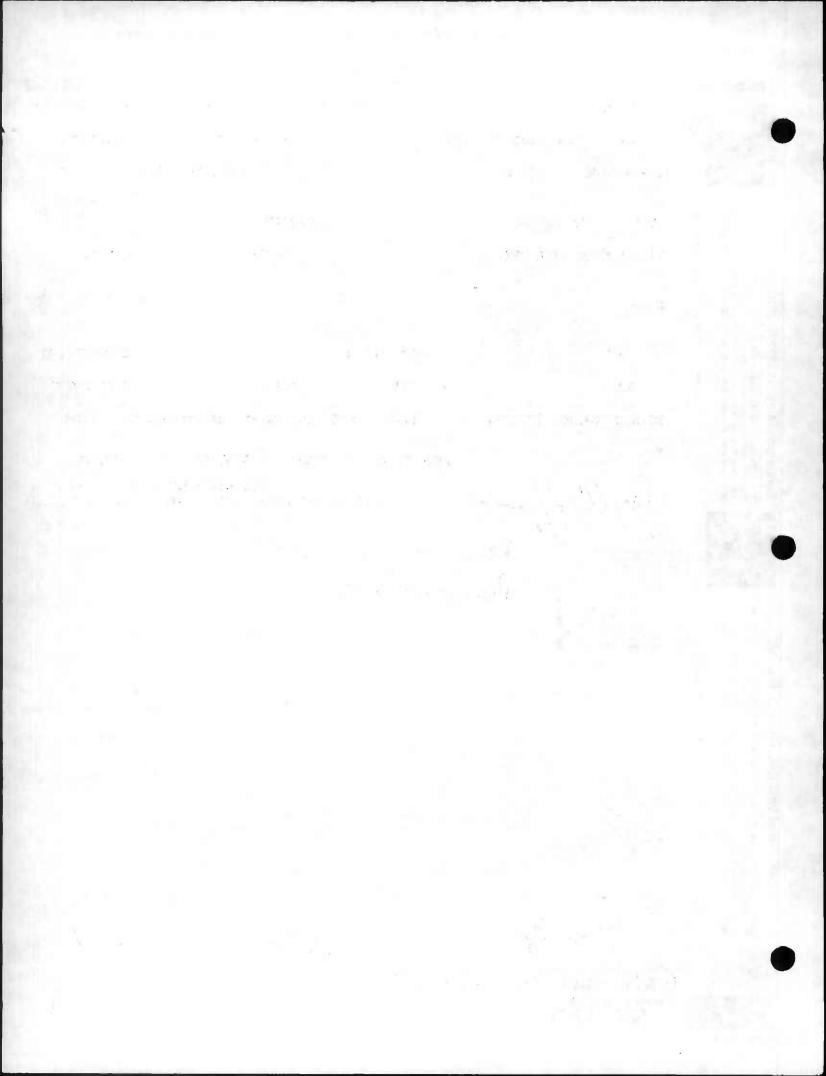
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ALCOHOLDS COUNTY DESCRIPTION OF

## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

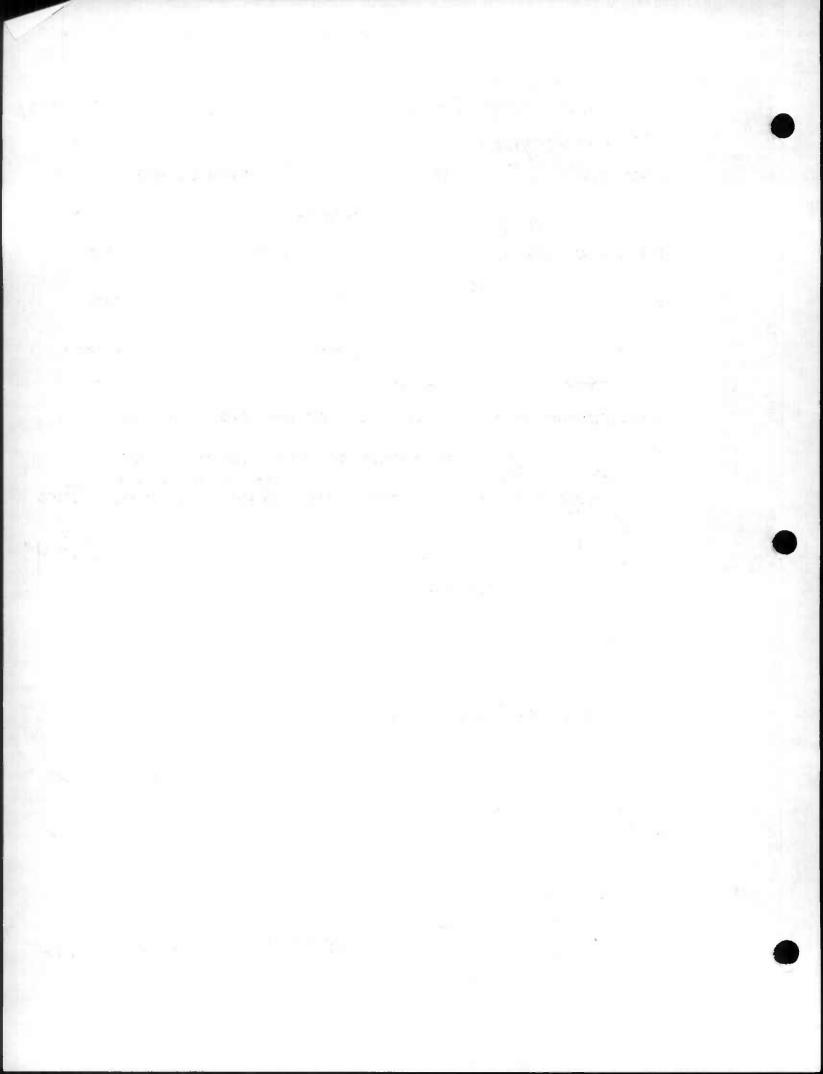
Formula   Special Name of Protein States of Protein States   Special Security Proteins   Physician /Medical	Decedent's Nan  JUL	ne (First, Middle, L	ast)			GESBE			2. Date of D. Month		98	3. Time of 4:40		
Usuar Residence of Decedent   10d. Clay. Town or Location   10d. Pack Steel and Number   10d. Expected   10d. Clay. Town or Location   10d. Pack Steel and Number   10d. Expected   10d. Exp		Part of the second				2		4b		IMORE			IMORE	
The part of the		215-09-	3140							8. Date of 8 (Month, DOCT.	rth ev. Year) 19, 1907	9. Birthp Cour	olece (Stete or ntry) N C	Foreign
MD   BALTIMORE   BALTIMORE   10, CRize of What Country?   11.3 SOOTTS HILL DRIVB   10, CRize of What Country?   11.3 SOOTTS HILL DRIVB   12, Vea Decoderd Ever's U.S.   13, Web Decoderd Congrif (Specify Yas or No Live State of What Country?   12, Vea Decoderd Ever's U.S.   13, Web Decoderd Congrif (Specify Yas or No Live State of What Country?   14, Paper A. Assertant Indian, No No Live State of What Country?   14, Paper A. Assertant Indian, No No Live State of Live State	dat dat		10b. County		10c. C	ity, Town or Lo						1		
Type   Character   Specify: WHITE   Sp	irecto		1	IMORE				_	TIMORE		10g. Citizen of	What Cour		
Specify   WHITE   Specify	ralD	1113 8	COTTS HI	LL DRIVI	Ε									
Trestories Name (Prist, Michae), Last)   Trestories Name (Prist, Michae), Last)   Trestories Name (Prist, Michae), Last)   Trestories Name/Relationship (Type, Print)	by	1 Never Mar		Armed F	orces? 2 X No ive					(Specify Yes or N arto Rican, etc.)	Ble	ck, White,	etc.	
Testing Name (right, Michae)   Testing Name (right, Michae)	mpleted	Elementary/Sec	ondary (0-12)	rede completed)		(Give	kind of work do DO NOT use ret	ne du	ion I <i>ring</i> most of w	rorking	16b. Kind of B			C
199. Informent's Name/Relationship (Type, Print)   190. Nating Address (Sireet and Number or Paral Route Number, City or Town, Stelle, 2p Code)   1113 SCOTTS HILL DRIVE BALTIMORE, MD 21208   200. Method of Disposition   1	Be	17. Fether's Neme	(First, Middle, Las	ot)	н		BEFER	1			e, Maiden Sumen	ne)		
### A   Donation 5   Other (specify)    21. Signation of Funeral days be Licenses    22. Name and Address of Facility    23. Signation of Funeral days be Licenses    24. Donation 5   Other (specify)    25. Signation of Funeral days be Licenses    26. Plant    27. Signation of Funeral days be Licenses    28. Part   Entry   the disease. of corporation    29. Certifier   the disease. of corporation    29. Part					)		-							
890 REISTERSTOWN ROAD PIKESVILLE, MD 21  23a. Part Enter the disease, of complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate filterive Back Oreset Part Issues. List one order cause on each line.  Part II. Other significant conditions, and the conditions contributing to death but not resulting in the underlying cause given in Part I.  Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  25b. Did tobacco use contribute to the cause of cause of cause (not death) and the cause of ca		1X Burial 2	□Cremation 3		State	cemetery, crer	metory or other p	olece,						
24a. Wes en eutopsy performed?  24b. Were autopsy is eveilable prior to completion of condidate of death?  1	n/Medical Examiner	disease or conditive resulting in death)  Sequentially list confirmed in the firmer of the cause. Enter Und Cause (Disease of that initiated even resulting in deeth)	onditions, mmediate lertying r injury ls	a. Pa	Due to (	or es a consec	quenca of):	le	me					
24a. Was an eutopsy performed?  24b. Were autopsy performed?  25. Wes case referred to medical examiner?  1   Yes   2   No		Part II. Other sign	ificant conditions	contributing to d	leath but not re	sulting in the u	nderlying cause	give	n In Part I.					
25. Wes case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Netural 2 Accident 3 DOA  28. Date of Injury Month, Dey Year)  28. Injury et Work?  3 Suicide 4 Homicide  28. Place of Injury - At home, farm, street, factory, office  28. Date of Injury occurred  28. Date of Injury Month, Dey Year)  28. Date of Injury - At home, farm, street, factory, office  28. Date of Injury - At home, farm, street, factory, office  28. Date of Injury - At home, farm, street, factory, office  28. Certifier (Check only or Town, Stete)	Completed by							+		per	formed?	of of	veilable prior to empletion of co death?	o ause
27. Manner of Death 1 Describe how injury occurred 28. Date of Injury M 1 Ves 2 No 28. Injury et Work? 1 Now Street and Number or Rurel Route Number of Route Number or Rurel Ro	Be	examiner?		Hospital:	Inpatient 2	☐ ER/Outnatie	nt 3□ DOA	Othe	/			ner (Speci	fv)	
29a. Certifier (Check only annul 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner es steted.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.		1 12 Netural 2 ☐ Accident	5 Pending Investigation	28e. Date (Mor		28b. Time o	f 28c. I		et ?	28d. Describe	how injury occu	rred		
		4 Homicide	determine	d 289. Plac	ling, etc. (Spec	ify)			e, dete end ple	City or T	own, Stete)			Der,
72(10) 4(2)(5)	Medica	(Check only	2□ Medical Exa	miner: On the b	pasis of examin	ation and/or In	vestigation, In m	ny opi	inion, death oc	courred at the time	, date and placa,	and due t	to the cause(s	)
30 Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)		<b>)</b>	1 80	8		00-1 CT	I I	)3	2683		81	316	78	



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State of Maryland / Department of Health and Mental Hygiene 2 6 6 5

	ŀ	I. Decedent's Name (First, Middle, La				moan	0 01 1	Death	2. Dete of De	Reg. No. eth	3.	Time of Death
hysician	_	MAXINE	Golde	ste	(n)				Month	ST Dey 25	Yeer 1990	143
/Medical xaminer		e. Fecility Neme (If not institution, pix					- 4	ib. City, Town, o	r Location of Deet	-		
		SINAI H	oso ta	1				1Sa H	mort		N	I/A
ral	Ca.	Sociel Security Number 6. S		ge (In yrs. I	ast birthday)	If Under Months	1 Year Devs	If Under 24 H	rs. 8. Date of Bir	th V Year)		(Stete or Foreign
or	-	218-22-0274 Usuat Residence of Decedent	□ M <b>X</b> XF	85	Yrs.	Wildingilo		110010	MARCH	4, 1913	Country)	MD
		0a. State 10b. County		10c. City	, Town or Loc						10d. ir	nside City Limits
Director			/A			1	TIM	ORE				Yes 2□No
		Oe. Street end Number  2211 ROGENE DRI	VE #104			10f. Zip	Code	212	09	10g. Citizen of	Whet Country? U.S.A.	
by Funeral		1. Marital Stetus  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceden Armed Forces 1 ☐ Yes 2 ☐ tf Yes, Give Yeer or Dates	? (No				ispanic Origin? on, Mexicen, Pu Specify:	(Specify Yes or No erto Rican, etc.)		e - American Inck, White, etc.  WHITE	dien,
Completed	-	15. Decedent's Ec (Specify only highest gre Etementary/Secondary (0-12)	ucation de completed) College (1-4or	5+)	16e. Deced (Give I life. D	ind of wor O NOT us	rk done d se retired	during most of w	rorking	16b. Kind of B	usiness/Industry	
ပိ	-	7. Fether's Neme (First, Middle, Last)				HON	MEMA		ame (First, Middle	Meiden Sumen	OWN HO	ME
To Be		JOSEPH		HE	RZFELD	1		LEN		moidon cumon	LONG	
-		19e. Informent's Neme/Reletionship (I							Rurel Route Numb		Stete, Zip Code	9)
	2	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐	Removal from State	e Ce	lece of Dispos emetery, crem	ition (Nem	ne of ther plea	:е)	Dete	20c. Locetion	City or Town, S	
		4 ☐ Donation 5 ☐ Other (Specif)  21. Signature of Fundamental Structure	10	MIK				ss of Facility	8/27/98		ORE, ME	
DUCE.		/aus	The_	_				ERSTOWN	OL LEVINS ROAD I	SON & BR		
n/Medical Examiner	1	Sequentielly tist conditions, f eny, leading to immediate beuse. Enter Underlying Cause (Diseese or Injury het initiated events esulting in deeth) Lest	e. SEI	Due to (or	es e conseques es e c	O W Jence of):	e					V
Physician	-	One II. Other classificant conditions	d.					D 1	ook Du			
by Phys		Pert II. Other eignificant conditions on Acute Re	/	D	1	-	euse giv	en in Pert I.		Yes 22 No	3 Probably	cause of death?
Completed t	-									en eutopsy ormed?	eveilebt	utopsy findings e prior to tion of ceuse 1?
Com									10	Yes 2 No	1 □ Yes	No
Be (		25. Wes case referred to medical exeminer?							eeth (Check only	one)		
2	L	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpetient			4 Li Muising	Home 5 ☐ Resi			
Medical Certification: To Be C	2	7. Manner of <b>p</b> eeth  1	28a. Date of tri (Month, D	ey Year)	28b. Time of Injury	M 2	8c. Injur Wor 1 🗆	y et k? Yes 2 □ No	28d. Describe	how injury occur	Der	
Certification:		3 ☐ Sulcide 6 ☐ Could not be determined	286. Piece of It	njury - At ho tc. (Specify	me, farm, stre	et, factory	, office		28f. Location ( City or To	Street end Numb wn, Stete)	ber or Rurei Rou	ite Number,
edicai		29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 2	rsicien: To the besi iner: On the besis end manners	of avaminati	vtedge, deeth ion end/or inv	occurred o	et the tin	ne, dete end ple pinlon, deeth oc	ce, end due to the curred et the time,	ceuse(s) end madate end place,	enner es steted and due to the	ceuse(s)
Me	2	9b. Signeture end fitte of Septile	n al	M	MD			593		Aug us		
	3	0. Name end address person who	completed cause of	deeth (Item		Print)	in	A1 1	OSPITI			
1 1			_	~ 1 ~	700		3 1 FU	v / v [ ]	~ ~ 1 / / /	- 6-00		



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 26616 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Physician Month 12mN Clarence Gnmes 98 August /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Pleasant View NSq. Home 410101d Natl. Pike MHAiry 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 219-32-4018 MAR 17, Director Maryland Usual Rasidence of Decedent 10a Stata 10h County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD 1 ☐ Yas 2√ No Carroll Mt. Airv Director 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 40101 Old National Pike 21771 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. ther than "natural", or ite 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other tha any hijury or other traumatic event, that pnos. 10 Unemployed N/A 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be Hilda Dyson Clarence L. Grimes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Holly A. Grimes/Daughter 241 Altamont Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) Metro Crematory, Inc. 08/29/98 Baltimore, MD 21. Signature Funaral Service 22. Name and Address of Facility Cremation Society of MD, Inc. Edward Edward reporchik 299 Frederick Road Balti

23a. Partl. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 **Physician** /Medical Immediata Causa (Final Arrythmal Minnle diseasa or condition rasulting in death) Examiner Examiner heart Cetherosciente coronary physician and tha burial-transit Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): General Athenoschenes Box 68760 Physician/Medical Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? on of Vital Records, P.O. 3 1 Yes 2 No 3 Probably 4 Unknown STOCKE, Hypertens, 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No Be 25. Was casa refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) this funaral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Attending 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Cartifiar edicai (Check only one) To the To the Complex 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MEWIN KORDON WID 4801 DORSEY Porive Elliott Ecty HAII

DHMH 16 Rev 6/95

State

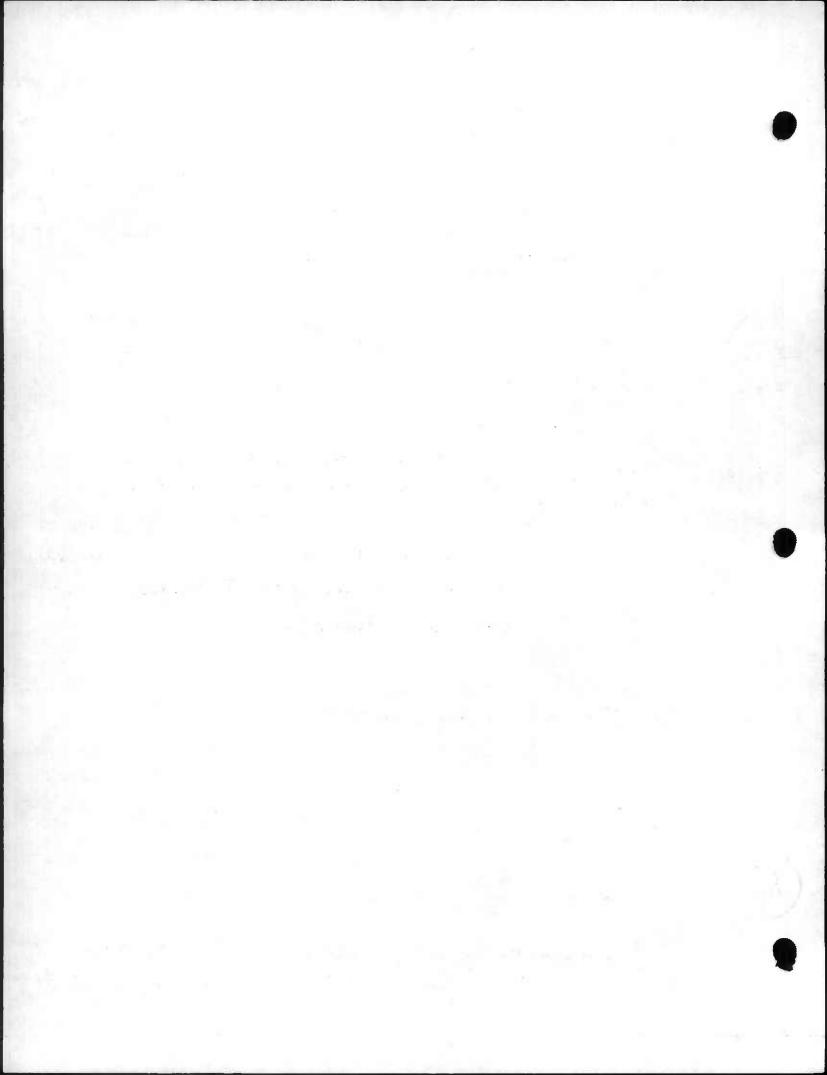
Registrar

31. Data filed (Month, Day, Year)

SEP

32. Registrar's Signature

21042



altimore N/A 8. Dete of Birth (Month, Day, Year) SEPT. 23, 1909 If Under 24 Hrs. 9. Birthplace (State or Foreign Min MARYLAND

4c. County of Deeth

10e. Sfreet and Number

10f. Zip Code 10g. Citizen of What Counfry? 21208 USA

2. Date of Death

August

16 OLD COURT RD., APT. 313 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 3 ₩ Widowed 4 Divorced

15. Decedent's Education

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2N No Specify:

Black, White, etc. WHITE Specify:

14. Rece - American Indian,

3. Time of Death

10d. Inside City Limits

1 Yes X No

(Specify only highest grade completed) Elementary/Secondary (0-12)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

16b. Kind of Business/Industry OWN HOME

17. Father's Name (First, Middle, Last)

COHEN

18. Mother's Name (First, Middle, Maiden Sumeme) FEINSTEIN

ANNA

MAYER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19a. Informant's Name/Relationship (Type, Print) MRS. RCNNYE WEIMAN (DAUG.)

20b. Place of Disposition (Name of cemetery, crematory or other place)

3500 ROUND HOLLOW RD. BALTO., MD 21208

20a. Method of Disposition 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

SHAAREI TFILOH

Date 20c. Location - City or Town, Stete 8/30/98

BALTIMORE, MD

ewie

22. SOL TEVINSON & BRCS. 8900 REISTERSTOWN RD.

PIKESVILLE, MD 21208

fmmediate Cause (Final disease or condition resulting in death)

. Renal Failure

cations that caused fine deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, no cause on each line.

Approximate Intervel Between Onset and Deeth

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

congestive Due to (or as a consequence of):

Due to (or es a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

College (1-4or 5+)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Cerebral Vascular Accident

24a. Was an autopsy

24b. Were autopsy findings available prior fo completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

1 Yes 2 No

25. Was case referred to medical 1 Yes 2 Volo 27. Manner of Death

Hospital: 1 physeienf 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury st Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

5 Pending

investigation

6 Could not be determined

AS 2402321 DE 9183 August 27,

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West Belvedere Balkmore Maryland 21215 Dawn Dill man Ewing 2401

31. Date filed (Month, Day, Year) State 1 1998 Registrar SEP

32. Registrar's Signature

**DHMH 16 Rev 6/95** 

Euroral Dire Hospital

within 2 To the I

with

72 hours after deeth

d 2 should be filed within 7/2 in end Mental Hygiene.
7 Is marked other than "ru

Pages 1 end 2 should be

Department of Health er Important; if item 27 is any Injury or other treu ones.

Funeral

by

Completed

Examiner

Physician/Medical

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Completed

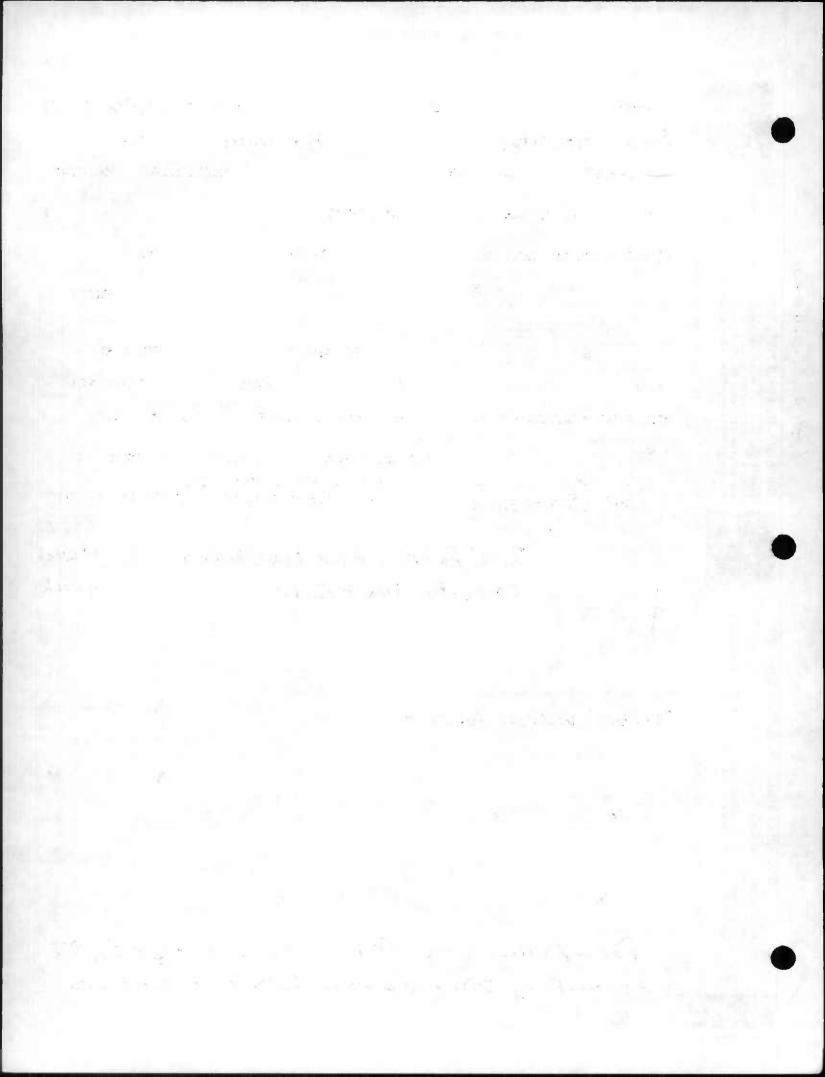
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Certification:

**Physician** /Medical Examine end -trans

The law requires that the death certificate be executed ettending physician e for use as the buriel-Records, P.O. Box 68760. ed by the e signed by t been si s certificate has t director, page 2 s Division of Vital Attending Physician: After this certification, funeral director, or Attending effer death. I Director: Aft d in by the fun



Months

GLEN BURNIE

HOMEMAKER

CEDAR HILL CEM.

10f. Zip Coda

Deys

Hours

Min.

7. Age (In yrs. lest birthday)

Yrs.

10c. City. Town or Location

80

the Maryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Madical Examinat must be notified at with Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23. Maryland 21215-0020 other t altimore, 0 permit. Page Department of Important: If any Injury or once.

**Physician** 

/Medical

Examiner

Funeral

Director

5. Social Security Number

218-76-0499

**Physician** /Medical Examiner

Division of Vital Records, funeral after deat Director: ò

Hospital 24 hours a 24 hours Funeral

To the P

Usuel Residance of Decedent 10a Stete Director MARYLAND 10e. Street and Number Funeral ò Completed Be 20 4 ☐ Donation 5 ☐ Other (Specify) 21 Signatury pl Funerel Service Licensee Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Les! Physician/M ģ Completed Be Lo Certification: 2 Accident

402 MELROSE AVE. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, Last) ALBERT THOMPSON 19e. Informent's Name/Relationship (Type, Print) GEROGE L. GOULDIN/SON 20a. Method of Disposition 1 Burial 2 □ Cramation 3 □ Removel from State

6. Sax

10b. Counts

1□M 20 F

ANNE ARUNDEL

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No Specify: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)

21061

16b. Kind of Business/Industry OWN HOME 18. Mothar's Name (First, Middle, Maiden Sumeme)

10g. Citizen of What Country?

UNITED STATES

14. Race - Amarican Indian

Black, White, elc

BROOKLYN, MARYLAND

23b. Did tobecco use contribute to the cause of death?

Specify: WHITE

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

BERTHA KRACH

3216 TARTRIAN COURT BALTIMORE, MD 21227 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20c. Location - City or Town, State AUGUST 27.

> 22. Name end Address of Facility KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

PULMONARY EDEMA

YEAR

3 DAYS

Approximate Interval Between Onset and Death

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

MARYLAND

Due to (or es a consequence of):

Due to (or es a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ONGESTNE

-AICURE

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was en autopsy performed?

1 Yes 2 No

24b. Were autopsy findings evailable prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 1 Matural 5 Pending 1 Yes 2 No

investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifiar 29c. Licensa number

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

D46962

29d. Data signad (Month, Dey, Year) AUGUST 24, 1998

M. SHIRAZI, M.D. NORTH ARMADEL HOSPITAL. MD 21061.

Registrar

edical

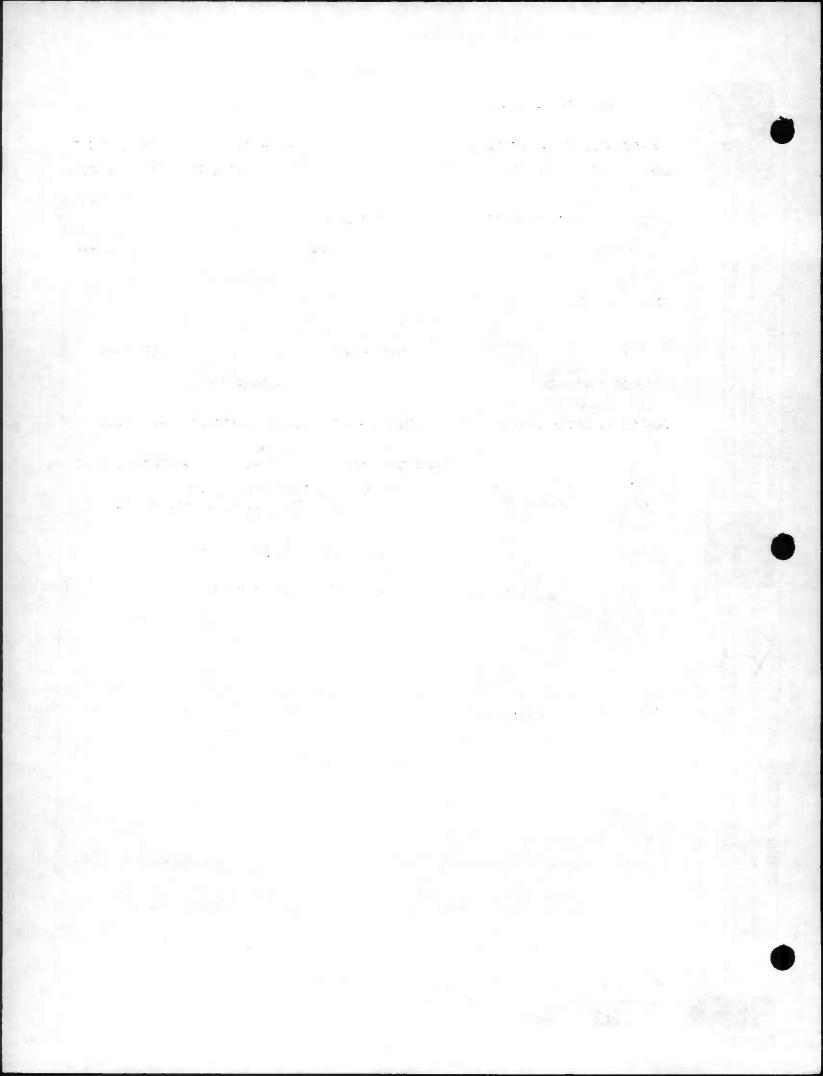
31. Date filed (Month, Dey, "Fear) 1 1998 SEP

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32. Redistrer's Signature

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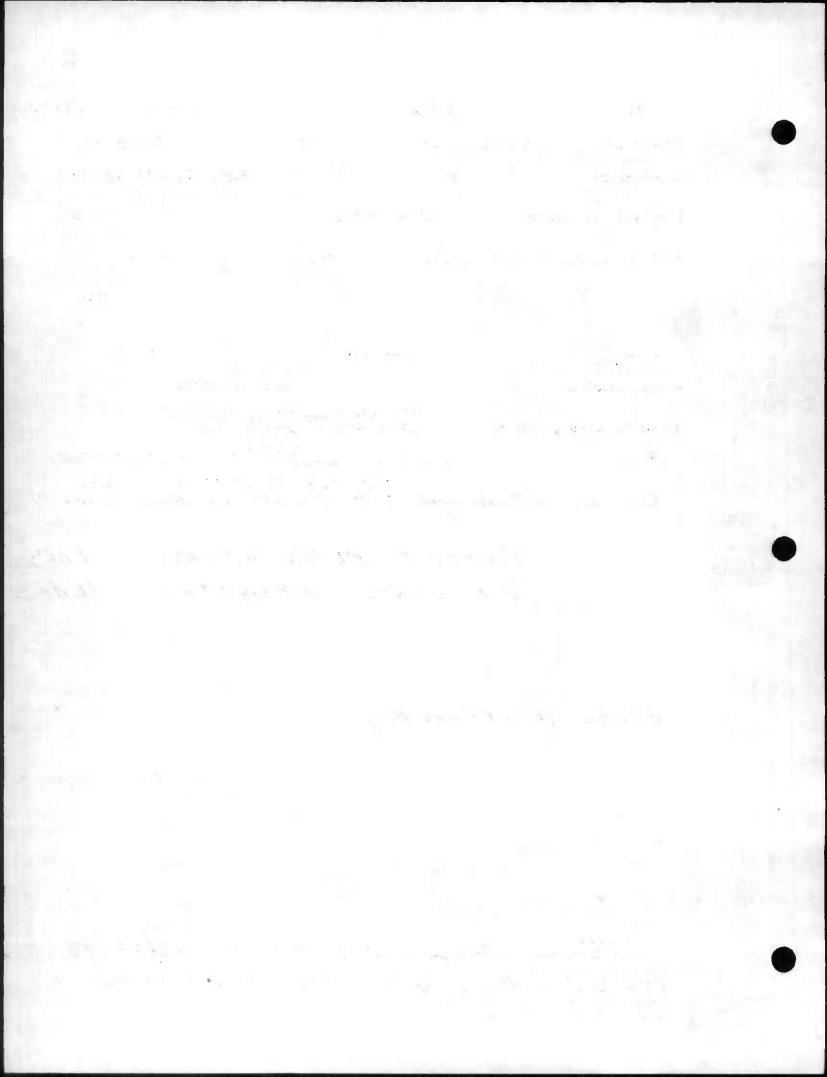


## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 24, 1998 8:00 P.M. LILLIAN **GORMAN** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hebrew Home Of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F Yrs. 82 Sept. 27, 1915 New York Director 086-03-7130 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mindical Examiner must be northed at Maryland Montgomery Silver Spring 1⊠ Yes 2□ No Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1111 University Blvd., West, #717 20902 U.S.A. deeth 1 Funerai 14. Race · American Indien, 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 25 Married Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) 2 should be f and Mentel F Sarah Breitbart Harry Sisselman 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: If item 27 is m any injury or other traun Isaac J. Gorman, Husband Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 8/26/1998 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Adelphi, Maryland Mount Lebanon Cemetery 21. Signeture of Funeral Service Licensee STEIN "HEBREW MEMORIAL FUNERAL HOME, INC. Vonald C. tottlemyer 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) HEART DISEASE Examiner MELLITUS Examiner physicial and s the bunal-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequenca of): certificate Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ed by the e 23b. Did tobacco use contribute to the cause of death? o signed by t 1 Yes 2 No 3 Probably 4 Unknown INSUFFICIENC that by Records, requires 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? The law pege 2 s has 1 ☐ Yes 2 No certificate Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 2 After this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 1 Maturel Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation efter death Director: / 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Directorn pletely filled in by 29a. Certifier edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 05885 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MONTROSE RD. ROCKVILLE 6121 LIPSON 32. Registrar's Signature Registrar

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Augus Holmes Wia 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth MEDICAL BALTO NA 1BERTY 8. Dete of Birth (Month, Dey, Ye If Under 1 Year | if Under 24 Hrs. 9. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F Months Days Hours Min 9-27-158 - 24 - 4328 Usuel Residence of Decedent Yrs. 10e Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No NIA MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? WINDSOR 21216 USA VENUE 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 14. Rece - American Indien. 11. Marital Status Black, White, etc. 1 Neyer Married 2 Married 1□ Yes 2☑No Specify. BLACK 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) OMESTIC 12 TH GRADE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) SIMPSON DARGAN JOHNNY IINY 19b. Meiling Address (Street, and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) BALTO ALMA WILLIAMS MELVIN MD. JAUGHTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removel from State ZION CEMETERY 8-31-98 KALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility ALLIGHN C- GREENE FUNERAL 21. Signeture of Funeral Service Licensee SERVICE VAUGHN NATL PIKE BAGO. 5151 BAUTO. 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) neumonia Due to (or es e consequence of): Que to (or es e consequence of) 6VOVASC Due to (or e consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 217 No 26. Plece of Deeth (Check only one)

**Physician** /Medical Examiner attending physician for use es the burie

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be

been signed by the should be deteched

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funeral

After this certificete hes

n 24 hours efter death.

Ne Funeral Director: Af
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or Attending Physician:

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**Physician** 

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d 2 should be filed within 72 hours efter death with the Merylen in end Mental Hygiene.
7 is merked other than "netural", or items 23s or 28s-f show traumatic event, the Medical Examinating that be notified as

permit. Peges 1 end 2 should be file Depertment of Health end Mental Hy Important: If Item 27 is marked other any liqury or other treumatic event PRES.

Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

25. Was cese referred to medical examiner? 1 Yes 2 No

Hospital:

5 Pending investigation

6 Could not be determined

1 Inpatient 2 ER/Outpetient 28a. Date of Injury (Month, Dey Yeer)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b Time of

3 DOA

28c. Injury et Work? 1 TYes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)

27. Manner of Deeth

1 Neturel

2 ☐ Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

29c. License number TU MID

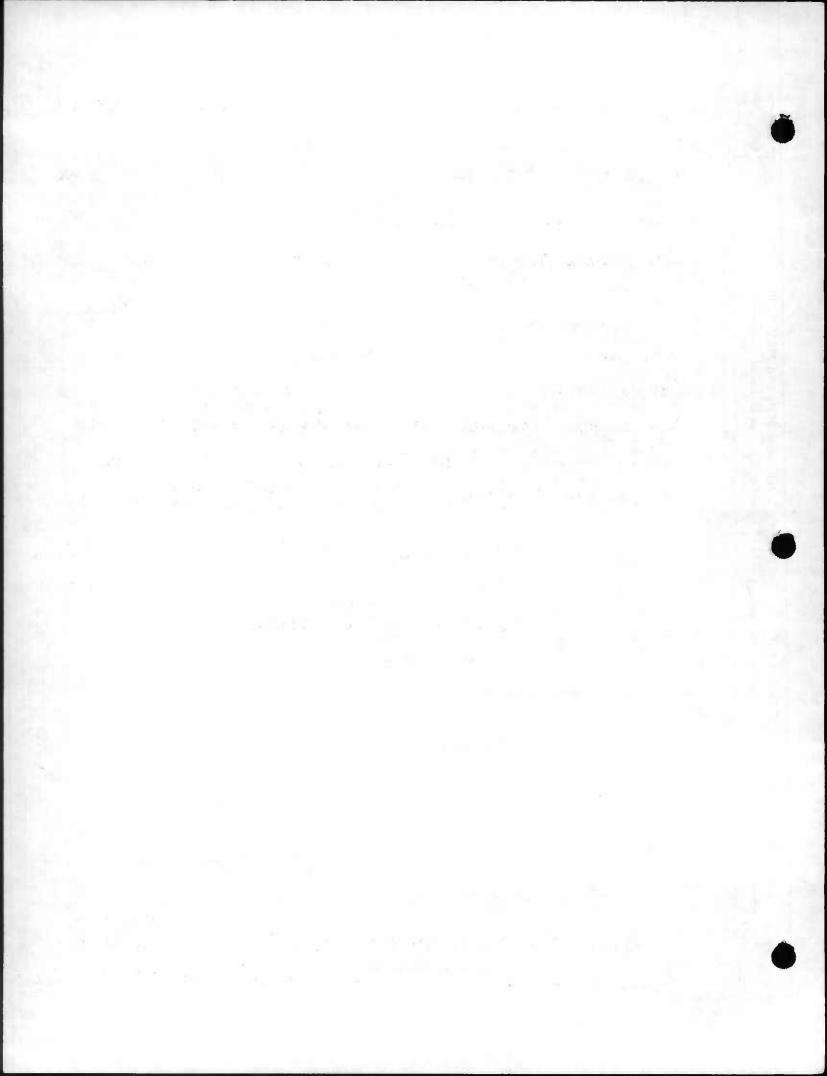
29d. Dete signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Icus M

State Registrar 31. Dete filed (Month, Day, Yeer)

32. Registras's Signature

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2662 Certificate of Death 3. Tima of Death 1. Decedent's Neme (First, Middla, Last) 2. Deta of Death AN Month 35 **Physician** /Medical 4b. City, Town, or Location of Death Name (If not institution, give street end number) 4c. County of Death Examiner OSPITAL KANDALLSTOWN NORTHWEST If Under 1 Year | If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Deys 212-12-0610 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Manyland ment of Heelih and Mental hygiene.

The file of the marked other than "natural", or items 23s or 28s-f show with the high should be an order than they or other traumatic awant, the Medical Earthier mail be notified at 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE NIA Directo MD 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 5509 21215 Funeral **JROUELAND** 4UENUE Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 2 No Specify BLACK Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PURCHASING U.S. ARMY 12 TH GRADE YRS 17. Fether's Neme (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumeme) Be 0 KAYNOR Cox LZKEL HATTIE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BURTON , MD. KANDALLSTOWN 4RLYCE **PEDDICOAT** 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State permit. Page Depertment of important: if any injury or once. NATIONAL CEMESERY 9-1-98 BALTO. MD 4 ☐ Donation 5 ☐ Other (Specify) MD. 21. Signature of Funeral Service Licansee 22. Name and Address of Fecility VAUGHN C. GREENE FUNDRAL SERVICE 5151 BALTO NATL' PIKE BALTO. MO. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be exacuted Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Couse (Diseesa or injury that initiated events rasulting in deeth) Last Due to (or es a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequance of): 88 USB signed by the atter 23b. Did tobacco use contributs to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by Records, 24b. Were autopsy findings eveilable prior to completion of cause of death? Be Completed page 2 should 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 Yes 2 No 8(1 certificate Division of Vital 25. Wes case referred to medical axeminer? funeral director, 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Medical Certification: To 1 ☐ Yes 2 DER/Outpatient 3 DOA 1 Inpatient this 28e. Dete of Injury (Month, Dey Year) 27. Menne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding investigation 1 Neturel 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicida Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. tompietely 2 Medical Examiner: On the basis of examiner and menner stetled. (Check only one) mination and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) within 2 ş 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 2

Registrar

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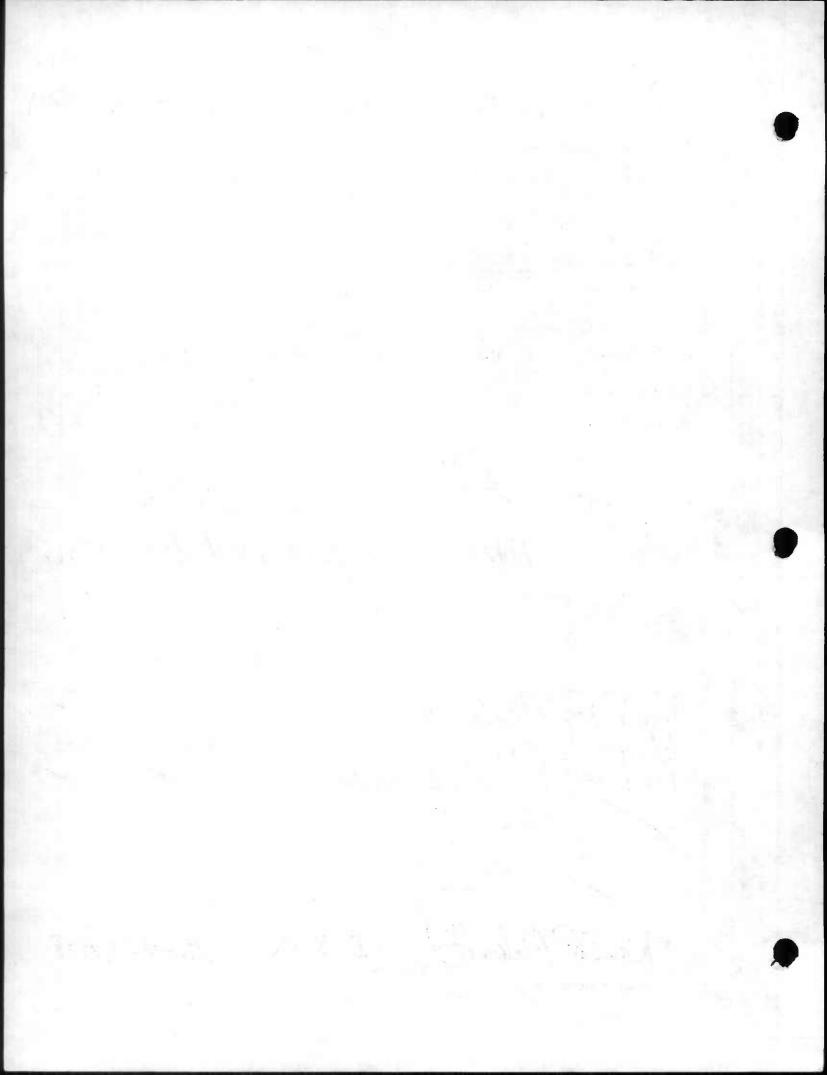
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Daniel Malone, M.D.

SEP 0 1 1998

31. Date filed (Month, Dey, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Item#10e,16a,16b,19b perFH G763 9/1/98 EW 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** HIMMEISTEIN 5:50 pM 1998 es/ie 26 August /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner - Maryland Hospital Baltimore, City University 01 If Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth Months | Days | Hours | Min. (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) XXM 2DF Months Days Yrs 218-76-4071 23, 1956 MARYLAND Usual Rasidance of Dacedant 10d. Insida City Limits 10a Stata 10h County 10c. City. Town or Location 1 ☐ Yas 2 No BALTIMORE Director BALTIMORE 10e. Street and Number Marnat 10f. Zip Code 10g. Citizan of What Country? 2963 MARNET ROAD APT. D 21209 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ② Who If Yas, Give Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. Navar Marriad 2 Married 1 ☐ Yas 2/7/10 Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Fiementary/Secondery (0-12) College (1-4or 5+) Sorter NONE NONE Chimes 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumema) Be **ABRAHAM** HIMMELSTEIN MIRIAM SIEGEL 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 2963 MARNET-ROAD ABRAHAM HIMMELSTEIN (FATHER) APT. D BALTIMORE, MD 21209 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) SHAAREI TFILOH CEMETERY 8/30/98 BALTIMORE, MD of uneral Service Lies 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complication that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only on cause on each line. Immadiata Causa (Final Brain Injury disaasa or condition resulting in daath) Examiner Fibrillation entricular Saquantially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last lown Syndr Physician/Medical Dua to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings aveilable prior to completion of cause of daath? 24a. Was an autopsy Completed 1 ☐ Yes 2 No X 1 TYes Be 25. Was casa rafarred to madical 26. Place of Death (Check only one) OL 1 Yas 2 No 27. Mannar of Daat! Certification: Natural 5 Panding investio 2 Accident

physician end the buriel-transit certificate be axecuted Box 68760. as usa 0 signed by the e P.O. Records, peed pege 2 certificate Division of Vital Hospital or Attending Physician: director, this funeral After after death.

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f shot traumstic event, "he wedical Exactine must be notified as

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any follury or other traumatic event," in Med police.

**Physician** /Medical

Examiner

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	Hospital: Inpatient	2 ER/Outpatient	3□	DOA Othar:	4□ Nursing I	Homa 5 ☐ Rasidanca 6 ☐ Other (Specify)
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28f. Location (Streat end Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) Certifying Physician: To tha best of my knowladga, daath occurred et the tima, data and placa, and dua to the ceusa(s) and mannar as stated

29a. Cartifian (Check only one)

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and maner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

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31. Data filad (Month, Day, Year)
SEP 1 1998

29b. Signatura and titla of cartifiar

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30. Name and address of person who completed caus (wheeth (Item 23a) (Type, Print) Frenont Avenue, Baltimore, MD 21201 121 South 32. Registrar's Signatura souls

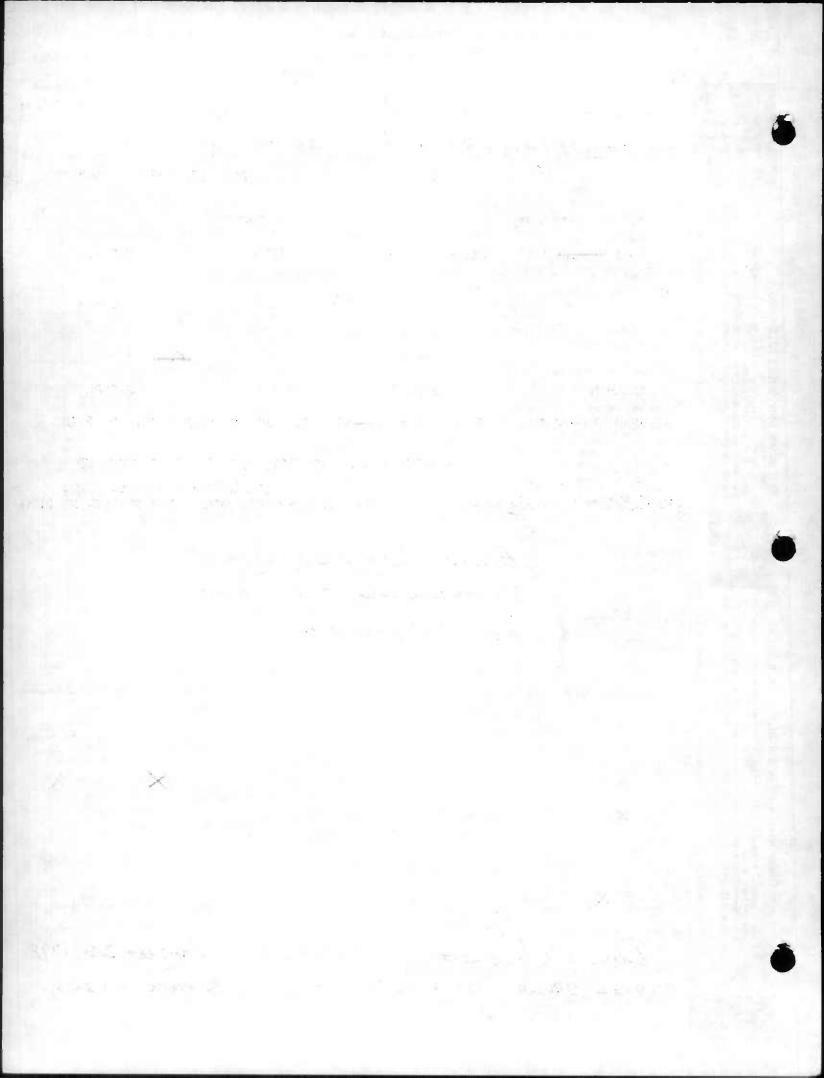
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## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 24 10:20 PM AuG. Carl Sheldon Henning /Medical 4b. City. Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner BALTIMORE ST. AGNES HEALTH CARE N/A If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Yeer, If Under 1 Year 9. Birthplace (Stete or Foreign 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** M 20 F Months Days Hours Yrs. 217-05-7326 Apr. 10, 1914 West Virginia Director Usual Residence of Decedent the Maryland 10a State 10b Count 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Modical Examinar must be notified at Md. Ellicott City 1 ☐ Yes 2 No Howard Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe with 1 21043 U.S.A. 2865 Marriottsville Road Funeral death 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after begartment of Haalth and Mental Hygiena. Introcrant: If them 27 is marked other than "natural", or then any Injury or other traumatic event 1 Yes 2 No It Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3XXVidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 Self Employed Fidelity Plastics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be Zelma Gay Gall William Jestus Henning 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) 2402 Smith Ave., Baltimore, Md. 21227 William Henning / Brother 20b. Placa of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-26-98 Baltimore-Washington Crematory Laurel, Md. 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc. 23a. Part1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. 2134 Willow Spring Rd., Balto., Md. 21222 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) PHELMONIA Week Examiner Due to (or as a consequence of): COPD Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca ot): Due to (or es a consequenca of): of Vital Records, P.O. Box Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown p 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 27, Menner ot Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Division 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Funeral 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and manner stated. edical 29a. Certifier (Check only one) within 2 To the 4 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 51494 1998 AUG MD w 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ST. AGNES CATON AVE HOSP 900 VIOLETA Rus 31. Date tiled (Month, Dey, Year) 32 Registrar's Signature State Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 5 8 wid in 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Northwest Hospita1 Randallstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Aug. 27, 1926 9. Birthplece (State or Foreign Country) VA 5. Social Security Number 7. Age (In yrs. lest birthday) Deys Hours Min XXM 2DF 72 Yrs. 225-20-4489 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥Yes 2□No n/a **Baltimore** MD 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21215 USA 4609 Homer Ave. 12. Wes Decedent Ever in U,S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Detes:WWII Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ Specify: Specify: 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) Forman Bethlehem Steel 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) Sandy Harding Lottie Blackwell 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1640 N. Ellamont St. Balto., MD 21216 Ethel Christian/niece 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition XX uriel 2 Cremetion 3 Removel from Stete Baltimore National Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility James A. Morton & Sons Funeral Home mes W 1701 Laurens St. Balto., MD 21217 Approximete Intervel Between Onset end Deeth 23a. Petal. Enter the disease, or combilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Cordio presparty Ischemic completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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Division of Vital Records, P.O.

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Physician/Medical Examiner

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Certification:

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25. Was cese referred to medicel examiner? 1 Yes 2 No

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27. Menner of Deeth

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Hospitel: 5 Pending investigation

28a. Dete of Injury (Month, Dey Year)

28b. Time of

Nnpatient 2□ER/Outpetient 3□ DOA 28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month. Dev. Year)

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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31. Date filed (Month, Day, Yeer) State 0 1 1998 Registrar

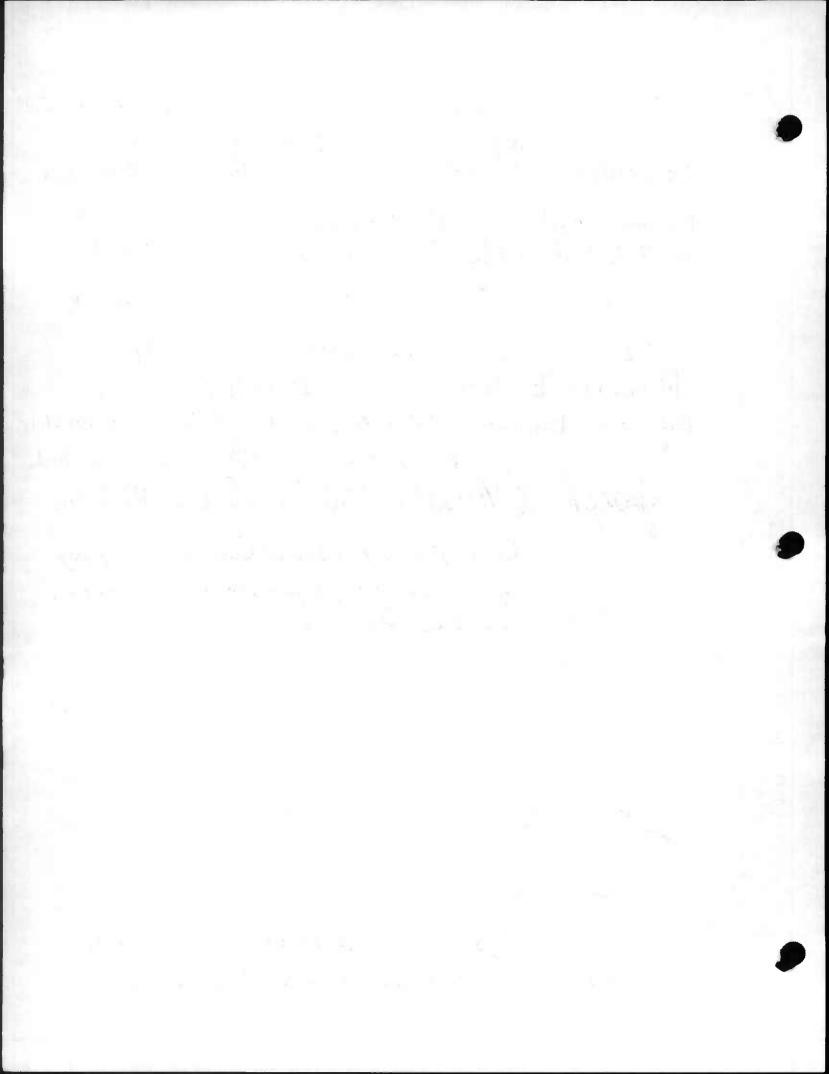
32. Registrer's Signature

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			Certificate of Death	Reg	J. No.	200	7 4 0
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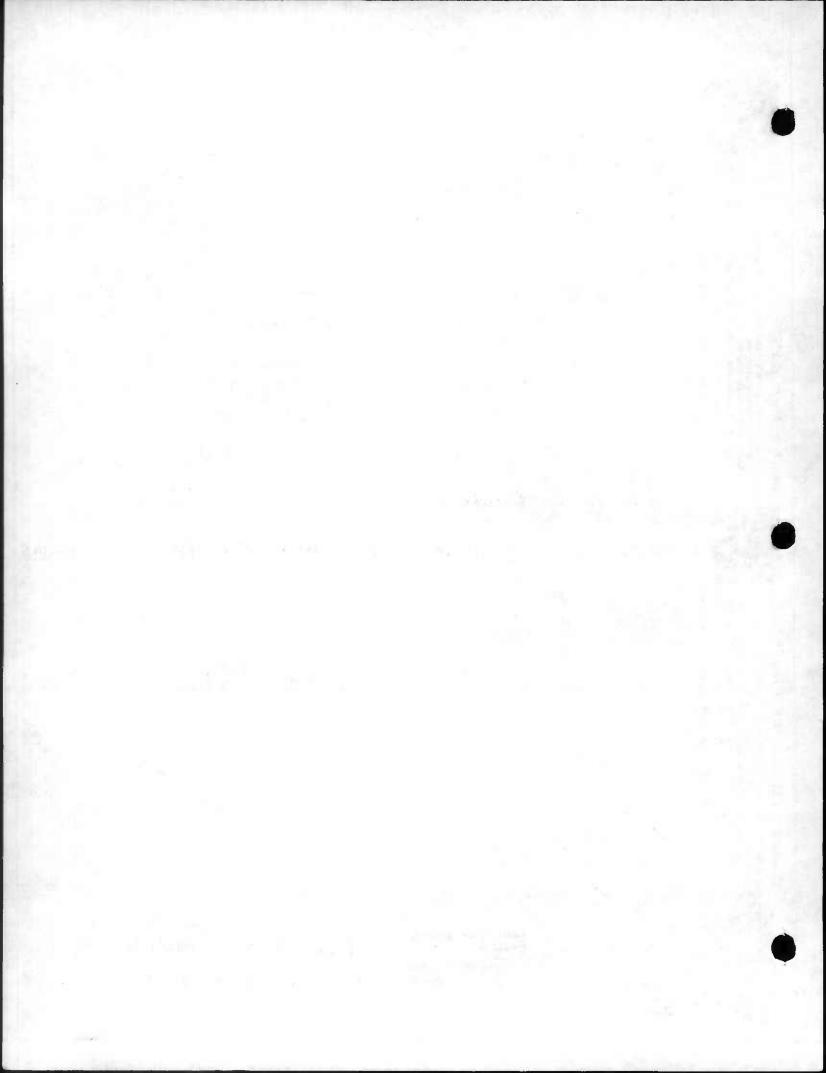
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Month Physician Patricia Ann Howerton 26, 1998 2:10 am August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Middle River 601 Kingston Rd. Baltimore If Under 1 Yaar | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months 1 M 2 X F 218 60 4119 Yrs. Director Jan. 7, 1950 Maryland Usual Rasidence of Dacedent 10c. City, Town or Location 10a, Stata 10b. County 10d. Inside City Limits 'hatural', or hems 23a or 28a-f show 1□ Yes 2□No Maryland Baltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 Kingston Rd. 21220 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merifel Sfetus 1 Nevar Married 2 Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: altimore, Maryland 21215-0020 Specify: White 1 Yas 2 XNo Specify 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) Coltega (1-4or 5+) Laborer Cleaning Service 9 17. Fathar's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be fill.
Department of Health and Mental Himportant. If Item 27 is marked other any injury or other traumatic event Be Hubert Williams Margaret M. Schuman 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Margaret Williams (Mother) 601 Kingston Rd. Baltimore, Md. 21220 20b. Place of Disposition (Name of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 XBurial 2 Cremetion 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Dublin Missionary Bap. Ch. 8/28/1998 Harford Co., Md. ra of funaral Sarvice Licensaa 22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each tine. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final HEAD AND NECK CANCER disaasa or condition rasulting in daath) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disease or injury that initiated events rasulting in death) Lest Dua to (or as a consequence of): Box 68760 Physician/Medicai Due to (or es e consequance of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown 3 d be det à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa refarred to medical axaminar? Be 26. Placa of Death (Check only one) To Hospital: Other: 4 Nursing Homa 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred the Hospital or Attending Priting 24 hours after death.
I the Puperal Director: After the mislately filled in by the funera After t Certification: 28b. Time of 28c. tnjury et Work? 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide 29a, Cartifiai 1 Certifying Physictan: To tha best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated. (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end fitla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) MEDICAL ONCOLOGY D 0050753 FELLOW August 26, 1998 30. Neme and addrass of person who complated causa of daath (Itam 23a) (Type, Print) 600 N. WOLFE STREET, ONCOLOGY 126, POALTHMORE, ND 21287

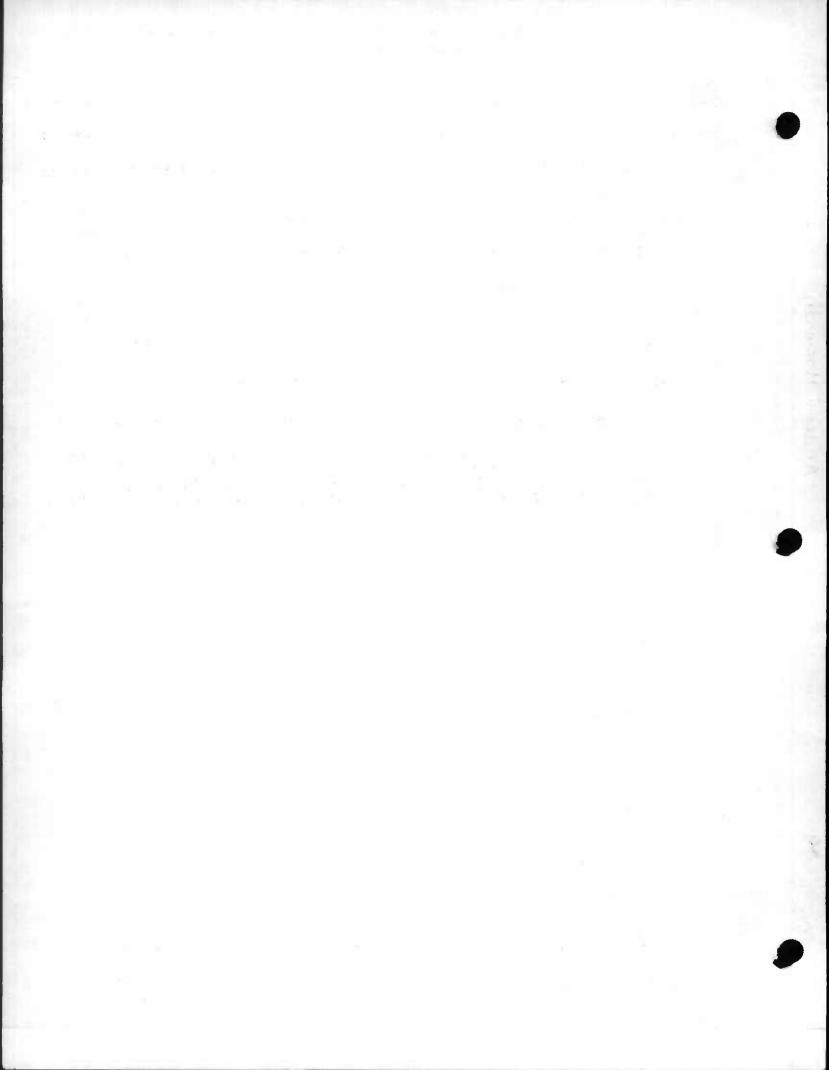
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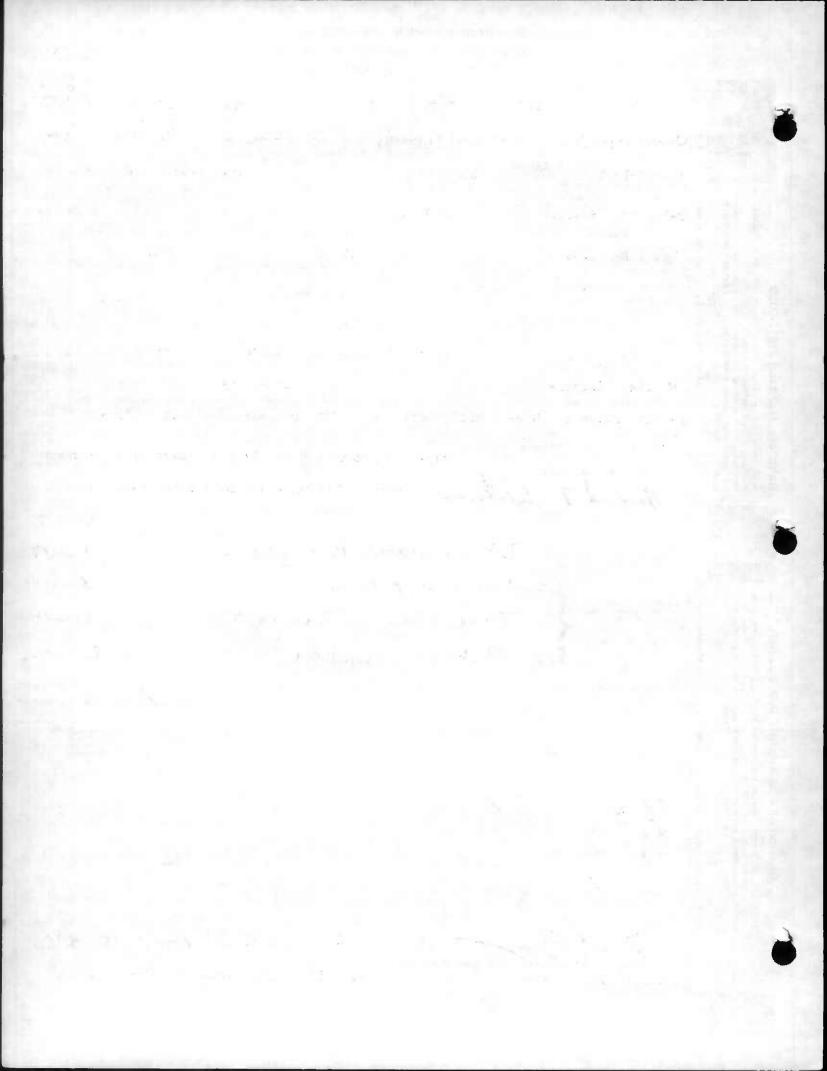
32. Registrar's Signatura



		Decedent's Name (First, Middle, Last,			ertificate of	Death	2. Dete of Dee	leg. No.	3 2	6627 3. Time of Deeth
Physic /Medi	cal	And 4a. Fecility Neme (If not institution, give	rew Horw	ath		4h City Tayon o	AUGUS	1		3:20 A
Examiı	ner	Frederick Villa		Center		Catons	ville	4c. County	of Deeth	ore
uneral rector		5. Social Security Number 6. Security Number 198–10–5647		(In yrs. lest birthda)	/ If Under 1 Year Months Deys			Year)	9. Birthple Country	ce (State or Foreig y) ylvania
X ==		Usuel Residence of Decedent  10a. State  10b. County		10c. City, Town or L	ocation				100	Inside City Limits
items 23a or 28a-f show iner must be notified at	tor	MD N/A			Ra1	timore				1 Nes 2 □ Ne
or 28	Director	10e. Street end Number		-	10f. Zip Code	CIMOLC	1	10g. Citizen of V	Whet Country	y?
8 23a		4031 Wilkens A				229			JSA	
"natural", or Item edical Examiner	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Example Forces?  1 XYes 2 □ Note of Year or Dates: 1		If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	Specify	e - Americar k, White, et	
natura lical	eted	15. Decedent's Edu (Specify only highest grade	eation	16a. Deci	edent's Usuel Occup	petion	notkina	16b. Kind of Bu		
ther than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)	e kind of work done DO NOT use retire Datcher				ΓA	
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em 27 is marked o other traumatic eve		19e. Informent's Name/Relationship (Ty Dorothy Horwath		4031	Wilken		Rurel Route Number ue Balti	more,	MD 2	1229
important: If item any injury or othe once.		20e. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		cometery, cre	position (Neme of emetory or other ple rematory	ce)	Dete 08/31/98	20c. Location -	City or Town	n, State
any inju		21. Signature of Funeral Service License Edward A.	gorchil	C	Page 22. Name end Address	n Socie	ety of M Road Bal	D, Inc	2.	
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should	Completed by F						24a. Wes e		com	e eutopsy findings eble prior to pletion of cause eth?
page 2	Com						1 🗆 Y	es 200 No	10	Yes 2 No
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the ch	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc.	y - At home, farm, s (Specify)		Yes 2 No	281. Location (S City or Town		er or Rurel F	Route Number,
od in by			elcien: To the best of	my knowledge, dea	th occurred et the ti	me, date end ple	ce, end due to the c curred et the time, d	euse(s) end ma	nner es siet	ed.
ne runeral Directory of the post of the po	edical	29a. Certifier (Check only one) Certifying Phye	ner: On the basis of e and menner state	ed.	nvestigetion, in my o					10 00036(3)
completely filled in by the funerel	Medical	(Check only 2 Medical Examination)  29b. Signeture and title of certifier	and menner state	ed.	29c. Licens		2	9d. Date signed		
To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Examin	and menner state	ed.	29c. Licens	se number	RETSTERS	29d. Date signed	d (Month, De	



1					Marylan		artment of rtificate of	Health and f Death		Reg. No.	2	5528
	Physician /Medical	1. Decedent's Name (Fir	st, Middle, Las	W.	Hi-	tche	ns		2. Dete of D	, Day	Yeer 98	3. Time of Deeth 04:55
	Examiner  Funeral  Director	4e Fecility Neme (If not it University of 5. Sociel Security Number 221-48-1472	2 Maryl or 6. Se	and Med	cical S	usten lest birthday) Yrs.	If Under 1 Yes Months Dey		s. B. Date of B	Ba(-	9. Birth	ne City place (State or Foreign two are
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	Aarylar f show ed at		. County Sussex			y, Town or Lo sboro	cation					1 ☐ Yes 2 ☑ No
	or 288-1 s	10e. Street end Number					10f. Zip Code			10g. Citizen of V	Whet Cou	ntry?
	23a or	Rt. 1 Box	179В				1993	39		USA		
020	72 hours after death with the Maryland natural, or items 23s or 28s-4 show face Examiner must be notified at steed by Funeral Director			12. Was Deceder Armed Force 1 Yes 25 If Yes, Give Yeer or Deter	s? No		Was Decedent of If Yes, specify Co	f Hispenic Origin? ( uban, Mexican, Pue o Specity:	Specify Yes or N rto Rican, etc.)		k, White,	
21215-0020	led within 72 ho lygiene. The Medical It, the Medical Completed	15.1 (Specify or Elemantary/Secondary	Decedent's Ed hy highest great (0-12)		or 5+)	(Give	DO NOT use reti	e during most of w		16b. Kind of Bu		
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Baltimore,	permit. Particular Permit Perm	21. Signature of Furteral	Service Licen	Wats	on	22	2. Name end Add					
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Division of Vital Records,	The law requires if pate has been signe page 2 should be Completed by								24e. We	s en eutopsy formed?	81	Vera eutopsy findings veileble prior to ompletion of ceuse if death?
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to	Physic and the control of the contro	1 Yes 2 No		Hospitel: 1 Inpa		ER/Outpetier	II SU DON	-	_	sidence 6 Oth		ify)
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Divisi	tal or Attending P na wher death. all Director. After that in by the funent led in by the funent Certification:		Could not be datarminad	28a. Place of building,	Injury - At he etc. (Specif	oma, farm, str	reat, fectory, offic	Ce Ce	28f. Location City or T	(Street and Numl own, Stata)	bar or Rui	ral Route Number,
	n 24 hospi n 24 hou he Funer pletsly III edical				of examine		vastigation, In m	tima, data end ple y opinion, deeth oc		, data end plece,	end due	to the causa(s)
	Town No	29b. Signeture end title of	45	in	_	MD	P	1020		August	25	, 1998 , 1998
	10	30. Name and address of Paniel A 31. Date fited (Month, Da	- Sin			Jth G	Print) Preene	st. B	a 14 imor	e, MI	> 6	21201
	State Registrar	SEP	1 1998		strers Signa	<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>	Spark	2				

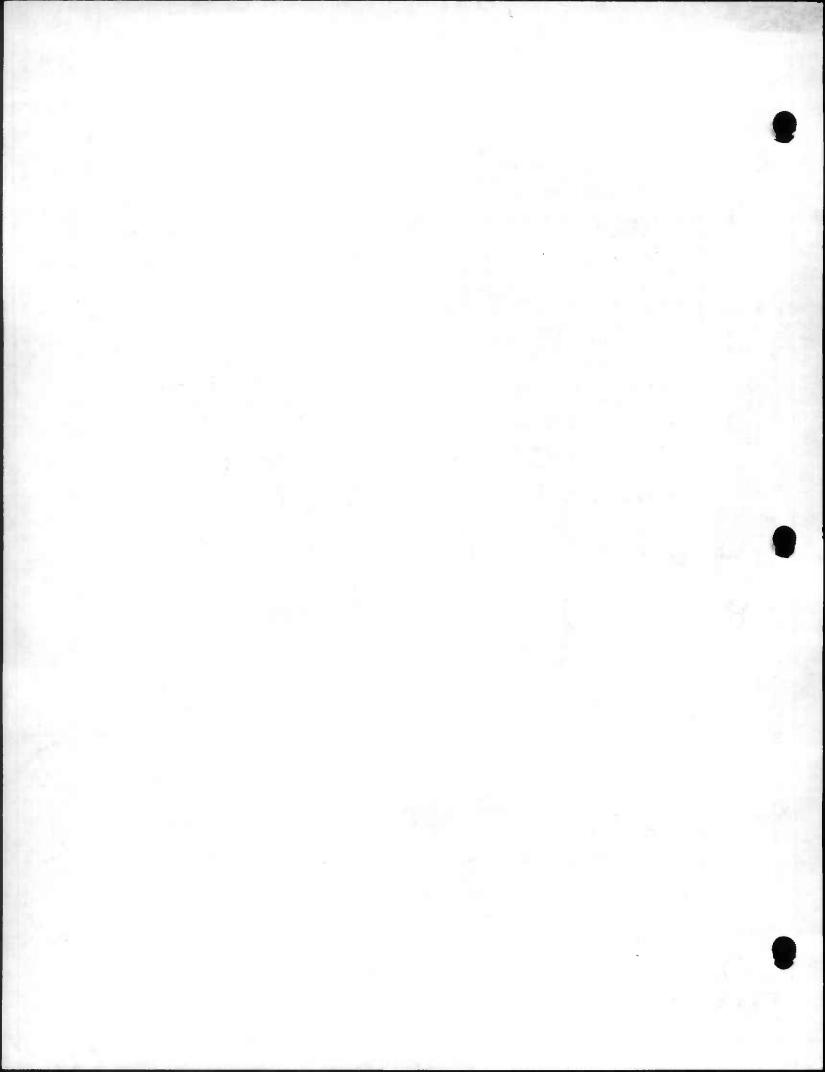


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician Johnson 29, 1998 4c. County of Death Annie 4b. City, Town, or Location of Death 1:15 PM Taye /Medical 4a Facility Name (If not institution, give street and number) Examiner Lan ham Prince George Magnolia Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex Funeral Months Days 1 M 2 F 179 Yrs. 212-74-3129 Director June 4, 1919 North Caroling Usual Residence of Decede the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. 1 Yas 2 No Directo Maryland Prince George Lanham r than "natural", or hams 23a or 28a-f the Medical Examiner must be notifie 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 6318 20706 Drive USA Brightlea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Hygiana. Hygiana. Watural', or ha 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à Black 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House wife None own 10th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked offty any injury or other traumatic event pages. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ferqueson MACK Barnes Lizie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ward - Daughter 20b. Place of Disposition (Name of cametery, crematory or other place)

20b. Place of Disposition (Name of cametery, crematory or other place)

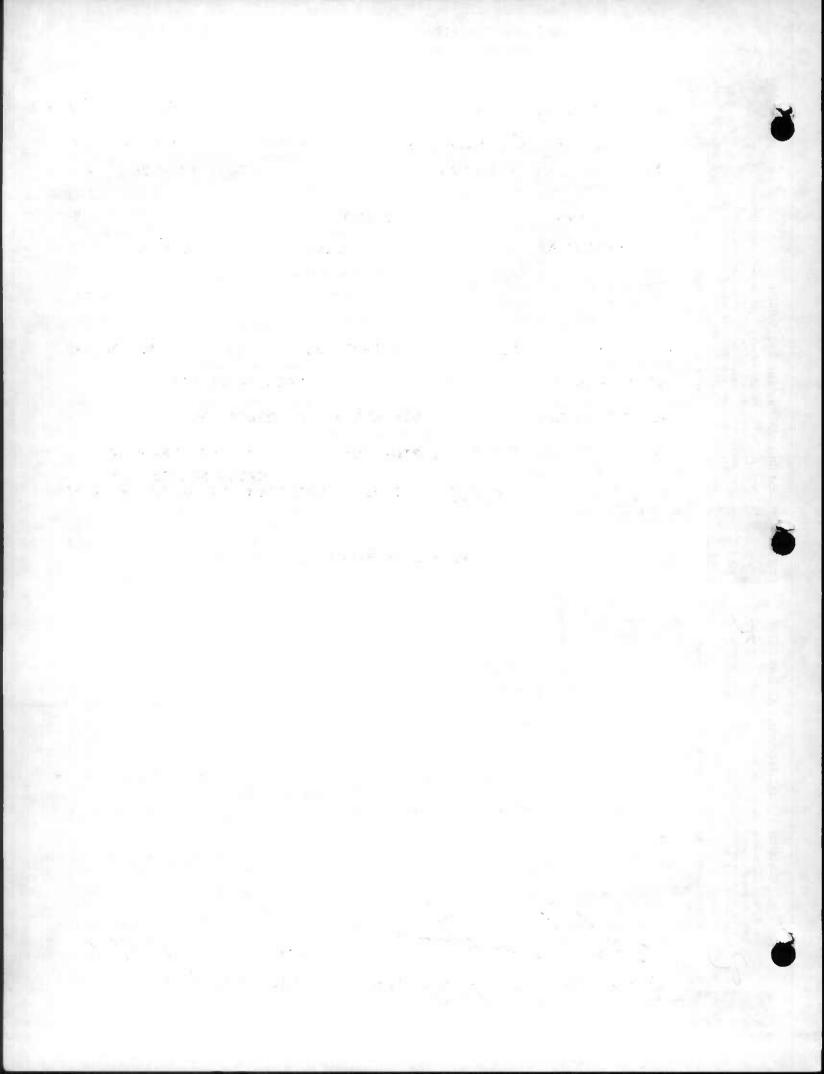
20c. Location - City or Town, State Audrey 20a. Method of Disposition 9/4/98 Annandale, Va. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) pleasant Valley memorial pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert B Boken A Chinn Funeral Service 2605 to Shirlington Rd. ARLington Va. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final 1/6 disease or condition resulting in death) Examiner Examiner physiciam and s the burief gransit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ... Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 8 25. Was case referred to medical examiner? 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending 1 UNatural To the Hospital or Attending within 24 hours effect deeth. To the Funeral Director: Affe completely filled in by the function. 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Control of the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aVAK 31. Date filed (Month, Day, Year) 32, Registrar's Signature SEP 0 1 1998 Registrar

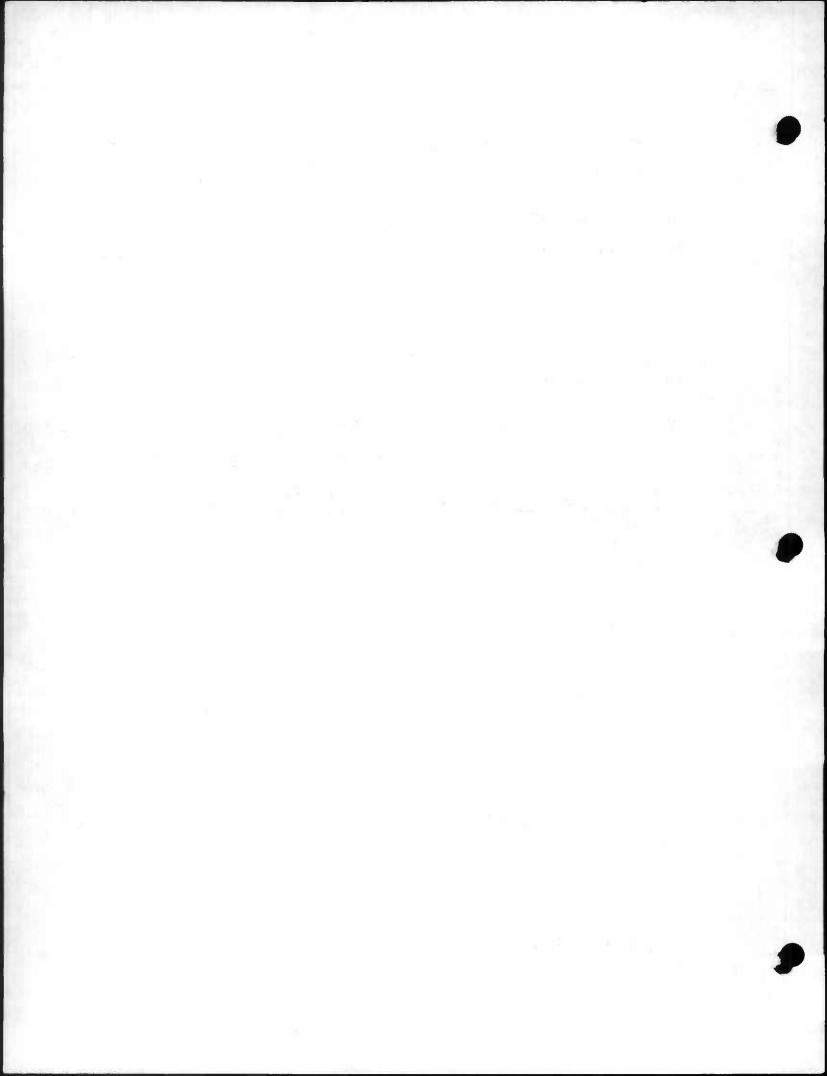


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Otato of Marylana	Certificate of	Death	Reg. No.	26630
Physician /Medical	1. Decedent's Neme (First, Middle, L A/c Ba/k 4e Fecility Name (If not institution, gi	y Johnson	4	2. Dete of D Month  4b, City, Town, or Location of Dee	Dey Yeer	21:50
Examiner Funeral Director	University of M 5. Sociel Security Number 6.	Paryland Medical Sex 7. Age (In yrs. les N/A	st birthday) If Under 1 Year Yrs. Months Deys	Baltimore	Battimaco	
and	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
Marylan P-1 show	MD N/A		BALTO			1 Yes 2 □ No
th with the Ma 23a or 28a-f s at be notified al Director	10e. Street end Number 926 ASHLAND (	CT	10f. Zip Code 2 1 2	02	10g. Citizen of Whet C	Country?
within 72 hours after deeth with the Maryland ana. than "natural; or items 23a or 28a-f show the Medical Examiner must be notified at sympleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12, Was Decedent Ever in U,S. Armed Forces? 1 □ Yes ※ No If Yes, Give Yeer or Dates:	13. Wes Decedent of If Yes, specify Cut  1 ☐ Yes 2 □ YNo	Hispenic Origin? (Specify Yes or Noan, Mexican, Puerto Rican, etc.)  Specify:	6 1 TOY -	
be filed within 72 hount tal Hygiana. d other than "natural' event, the Medical Ex	15. Decedent's E (Specify only highest gi	ducation ede completed)	16e. Decedent's Usuel Occu (Give kind of work done	during most of working	16b. Kind of Busines	s/Industry
within ana.	Elementary/Secondary (0-12)	College (1-4or 5+) N / A	UNEMPLOY		UNEME	LOYED
other vent, 1	17. Father's Name (First, Middle, Las	•		18. Mother's Name (First, Middle		
should be and Mantal marked o imatic ev	DARYL JOHNSON	J		LATONYA BAI	LEY	
d2: ther trau	19a. Informant's Name/Relationship LATONYA BAILI	EY	926 ASHLAN	t end Number or Rural Route Num D CT BALTO, M		, Zip Code)
nit. Pegas 1 en artmant of Heal oriant: If Itam 2 Injury or other	20e. Method of Disposition  1 Burial 2 Cremetion 3 4 Donetion 5 Other (Special Control of the Co	Removel from State	ce of Disposition (Neme of netery, crematory or other place ZION CEM	Date 9-1-98	BALOT, M	
permit. Departm Importar any inju	21. Signature of Foreign Service Lice	Detto	22. Name end Addr	DEITS	UNERAL HO BALTO, MD	
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Necrotiz	ene entero col	itis		Onset and Deeth
ding physicing and sa as the buriel-trensit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest	c	s e consequenca of):			
requires that the death carti een signed by the ettending hould be dateched for usa a	Pert II. Other significent conditions	contributing to death but not resulti	ing in the underlying cause g			te to the cause of deeth
s been s 2 should					is en eutopsy 24b formed?	o. Were autopsy findings eveilable prior to completion of cause of deeth?
Com Com				1,5	Yes 2□No	1 ☐ Yes 2,届No
Physician: The rhis certificata ral director, pag	25. Wes case referred to medical examiner?	Hospital:	0	26. Piece of Death (Check only		201
After thi funeral funeral	1 Yes 250 No  27. Manner of Deeth 1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not l	28e. Dete of Injury (Month, Day Year)	8b. Time of Injury M 1	iny et 28d. Describer 28d. Percriber 28d. Percriper	e how injury occurred  (Street end Number or	
To the Hospital or Attanding I within 24 hours after deeth. To the Funeral Director: After completaly filled in by the funer Medical Certification	4 Homicide determined	building, etc. (Specify)		City or T	own, State)	
n 24 h		miner: On the besis of examinetion end menner steted.	n end/or investigation, in my	ime, dete end plece, end due to th opinion, deeth occurred et the time	, date end place, end d	ue to the ceuse(s)
withiu To th	29b. Signature and title of bertifier	10-11		se number	29d. Date signed (Mo	nth, Day, Yeary
0)	Micel	1110	P	11216	8/28/	28
16	30. Neme and eddress of person who	completed cause of deeth (Item 2		I medical syst	to M	
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Signatur	o Harygne		4/1	
Registrar	SEP 1,1998	No.	B. Spar	KS		



ciar lica		1. Decedent's Neme (First, Middle, La	ist)	C				2. Date of De			. Time of Death
	al .	EDWARD C		ILZ				Month 08		10	11:5614
ine		4a. Fecility Neme (If not institution, given JOHNS HOPKINS BAY		AT CENTRE	2	4b.	City, Town, or BALTIM	Location of Deet!	1 4c. County	of Deeth	
		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birtho	1 60 4 5 4	er 1 Year	If Under 24 Hrs		th Voorl		(State or Foreign
	-		M 2□F	67 Yr	s.	Deys	Hours Min.	OCT.30	1930	MARYL	
	1	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town o	or Location					10d.	Inside City Llmits
1	50	MD BALTIM	ORE	EAS	STWOOD						1□Yes 2□No
	Director	10e. Street end Number 7289 BRIDGEWOOD	DRIVE		10f. Zi	ip Code	21224		10g. Citizen of	Whet Country?	
-	Funeral	11. Maritel Stetus	12. Was Decedent E	Ever in U,S.	13. Was Dece	edent of His	penic Origin? (S	pecify Yes or No		e - American I	
Paris	2	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  NTYes 2 □ N  If Yes, Give  Year or Detes:	48-'52	1 ☐ Yes		Mexicen, Puerl Specify:	to Hican, etc.)	Specif	ck, White, etc.  WHIT	E
Sala	ered	15. Decedent's E (Specify only highest gre	ducetion	16e. D	ecedent's Usu Bive kind of w	ork done du	on ring most of wo	rking	16b. Kind of B	usiness/Indust	ry
1	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	fe. DO NOT U				TOM MOT	OR OPE	RATTOR
	Se l	17. Fether's Neme (First, Middle, Last				1	8. Mother's Nar	ne (First, Middle,			
40	0	JOSEPH A. JANKIET	WICZ				FRANCE	S KEY			
		19a. Informent's Neme/Reletionship ( CATHERINE JANKIE)						ural Route Numb			
	-	20e. Method of Disposition	WICZ/WIFE	20b. Plece of D	isposition (Ne	eme of	D DRIVE	BALTIN Date	ORE, MA 20c. Location		
		1 N Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif			WN CEM			8/31/98			
	-	21. Signature of Funeral Service Licer			22. Name e	nd Address	of Fecility	& SON, ]		id, rai	KITEMED
Andinal Evaminar	edical	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Lest	b. METAS	Due to (or es e cor  Due to (or es e cor  Due to (or as e cor	UNE (	CANCE	R				
5											
Madinia	£	Pert II. Other elgnificant conditions of	ontributing to death bu	t not resulting in th	ne underlying	ceuse niver	in Pert I	23h Did	tohacco uee co	ptribute to the	cause of death
U Dhuelalann	y Priysic	Pert II. Other eignificant conditions of						4.04			
Managed by Physician/M	2							1 X		3 Probabi	y 4 Unknow
Pic	2							1 A 24a. Wes	Yes 2□ No en eutopsy	3 Probability Probability 24b. Were eveilable comple of deer	y 4 Unknow
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edical Cartification: To Be Completed by	section certification: 10 be completed by	25. Wes case referred to medical examiner?  1  Yes 2 No  27. Menner of Deeth  1 Neturel 5 Pending investigation  3 Suiclde 4 Homicide 6 Could not be determined  29a. Certifier (Check only one)	Hospital: 1 Inpatier  28e. Date of Injun (Month, Day)  28e. Plece of Injun building, etc.  syelclan: To the best of and manner state	nt 2 ER/Output y Year) 28b. Tim Inju ry - At home, farm . (Specify)  I my knowledge, dexaminetion end/or	etlent 3 Detection of the of the of the of the often of the occurred or investigation and the occurred or investigation are often of the occurred or investigation or investiga	2° To  OA Other 28c. Injury e Work? 1 □ Ye  ry, office  d et the time n, in my opin	26. Place of Dec  4 Nursing Heat  by 2 No  dete end place  number	24a. Wes performent of the control o	Yes 2 No en eutopsy med?  Yes 2 No one) dence 6 □Oth how injury occur  Street end Numb wn, Stete)  ceuse(s) end me date end place,	3 Probable  24b. Were every ev	ole prior to a bit on of cause th?  Double Number,  d. cause(s)



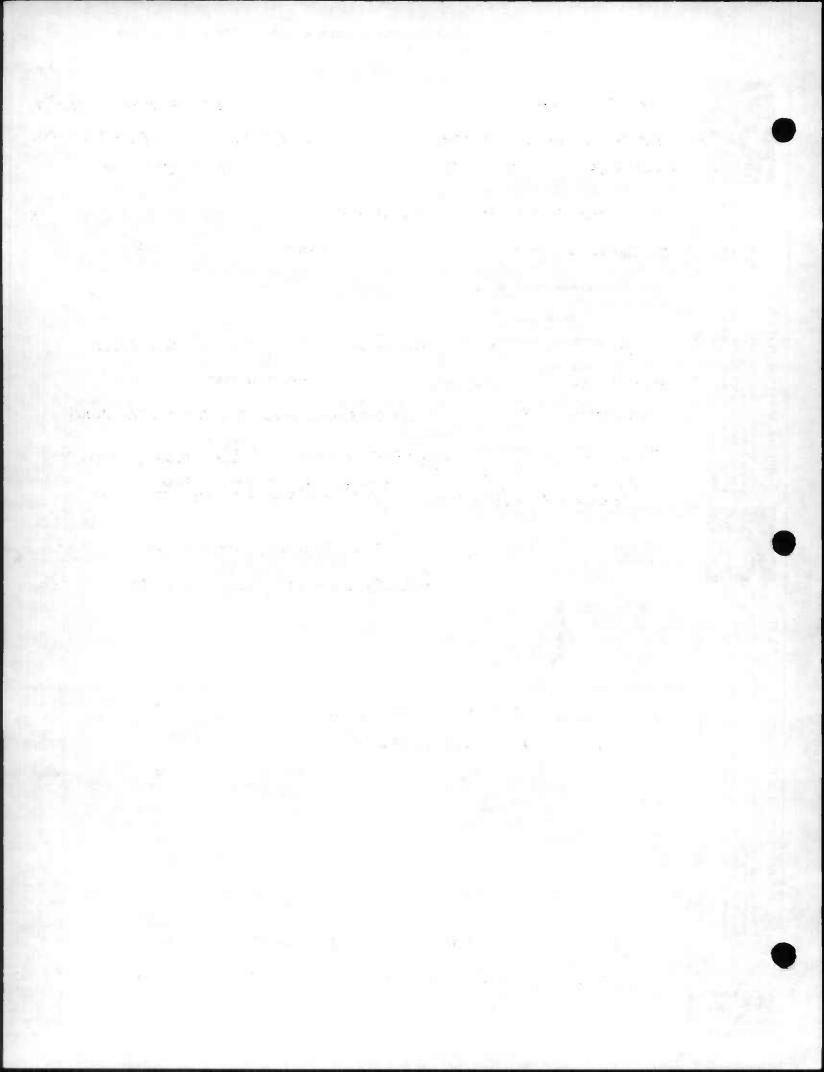
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 2:16a **JOHNSON** 1998 AUGUST Physician **JAMES** /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE CITY THRE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Dete of Birth 5. Social Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Days Months Hours 216-10-684 Yrs 921 MARI Director Usual Residence of Decede death with the Maryland 10a. State Town or Location 10d. Inside City Limits ms 23s or 28s-f show 1 Pres 2 No Director more MARU 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was 212 Rems : 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Bleck, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hyglene. In them 27 le marked other than "naturel", or he iry or other traumite avent, he ledged is antic 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marri Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify Specify: 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Be ertha 0 onw A ONYSOY 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, cremetory or other plea den 20c. Location - City or Town, State hos of Disposition Detp 1 DBurial 2 □ Cremetion 3 □ Removal fro permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) timor Cemelery 22 Name and Address 21. Signature of Funeral Service Dick ARS 01/00 10 Edmondson 23a. Pert1. Enter the disease, or complications that quited the death. Do not enter the mode of dying, such as cardiac of respinshock, or heart tailure. List only one cause on mentione. Approximata Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CARDIAC ARREST 1 hr Examiner Due to (or es a consequence of): Physician/Medical Examiner CORONARY ARTERY DISEASE 2yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): END STAGE RENAL FAILURE 2yrs Box 68760 Due to (or as a consequence of): resulting in de P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yea 2 ☑ No 3 ☐ Probably 4 ☐ Unknown PERIPHERAL VASCULAR DISEASE of Vital Records. à 24b. Ware eutopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? Completed HYPERTENSION DIABETES 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of no 1 ONatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 29, 1998 murle MD J Hopkus KAREN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 600 N Johns Hoplums Baltumore Hospital Wolfe St, 31. Date filed (Month, Day, Year) 32/Registrar's Signature Registrar

8 JHH 23 PH 1: 26

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death AUGUST 29 1998 **Physician** 11 PM EDNA E. JORDAN /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL CO. GLEN BURNIE MARINER HEALTH OF GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 26 1905 9. Birthplece (State or Foreign Country)
Penna. 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 ☐ M 2 🕏 F 93 218-09-4529 Yrs. **Director** Usuel Residence of Decedent with the Maryland 10e State 10b County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Glen Burnie Anne Arundel Co. Md. 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "naturel", or items 23a or the Medical Examiner must be 21060 USA 132 Dorchester Road Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Merital Status Pages 1 end 2 should be filled within 72 hours after and of Health and Mentel Hygiene.
Int. If Item 27 is marked other than "naturel", or ite 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4*o*r 5+) Home Owner Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Be Minnie Wagner James A. Orr 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 132 Dorchester Road, Glen Burnie, Md. 21060 Albert Jordan (Son) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Sept. 02 20c. Location - City or Town, Stete 20a. Method of Disposition 1 XBuriel 2 Cremetion 3 Removel from State Cedar Hill Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 1998 Brooklyn Park, Md. 21. Signature d 22. Neme end Address of Fecility McCully-Polyniak Funeral Home 130 E. Fort Ave. Baltimore, Md. 21230 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause or each line. Approximete Intervel Between Onset end Deeth **Physician** ACUTE MYOCARDIAL INFAR CTION
Due to (or as a consequence of): /Medical Immediate Ceuse (Final disease or condition resulting In deeth) Examiner GENERALIZED ARGELIOSCLEROSS Examiner physicien and the burial-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest that the death certificete be execu P.O. Box 68760, Physician/Medical Due to (or as e consequence of): attending pl for use as t Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? CENERO VASCULAR-ACIDENT 1 Yes 2 No 3 Probably 4 Unknown igned to Division of Vital Records, þ PERMANER PACEMALER. 24b. Were autopsy findings evallable prior to completion of ceuse of deeth? 24a. Wes en eutopsy Completed page 2 1 ☐ Yes 2 No 1 ☐ Yes 200 No certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Neturel eftar death. Director: Aft 1 ☐ Yes 2 ☐ No **e** ☐ Accident 6 Could not be determined 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funerel D Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

| Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture end title of cagifier D-22609 M.D. AUGUST 31-1998 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 2445 FURNACE BRANCIA Rd GLEN BURNEHO 21060 RUBEN RFIDER M.D. 31. Dete filed (Month, Dáy, Year) 32. Registrar's Signeture State oaks Registrar SEP



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. --1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month OS 2:25 Pm **Physician** Marius Johnson 27 /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Country)

June 23, 1903

9. Birthplace (State or Foreign Country)
Connecticut 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Months Yrs. 220-44-0171 95 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 1 Yes 2 No Director MD Baltimore Towson 10e, Street and Number 10f, Zip Code 10g. Citizen of Whet Country? 159 Versailles Circle, Apt. 21204 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Gynecology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank M. Johnson Maybel Pitkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 159 Versailles Circle, Apt. B Towson, MD 21204 Rosalie J. Johnson/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 08/28/98 Baltimore, MD 21. Signeture of Funeral Service Licent 22. Name and Address of Facility Cremation Society of MD, Inc. ingue Gregorchik Edward A. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in death) 12 mas Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Anor cerebrovascular Accident à 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Haspice 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Osler or Balto his

29d. Date signed (Month, Day, Year)

Marius Johnson

**Funeral** 

Director

"natural", or items 23a or 28a-f show

7 is marked other than "nature traumatic event, the Medical

permit. Peges 1 end 2 should be f Depertment of Health and Mantel H Important: If Item 27 is marked of any Injury or othar traumatic eve

**Physician** /Medical

Examiner

physician and the buriel-transit

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page 2

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filed within 72 hours efter death with Hygiene.

Baltimore, Maryland 21215-0020

signed by d be detacl or Attending Physician: value 24 hours after de To the Funeral Directo completely filled in by th

> State Registrar

Medical

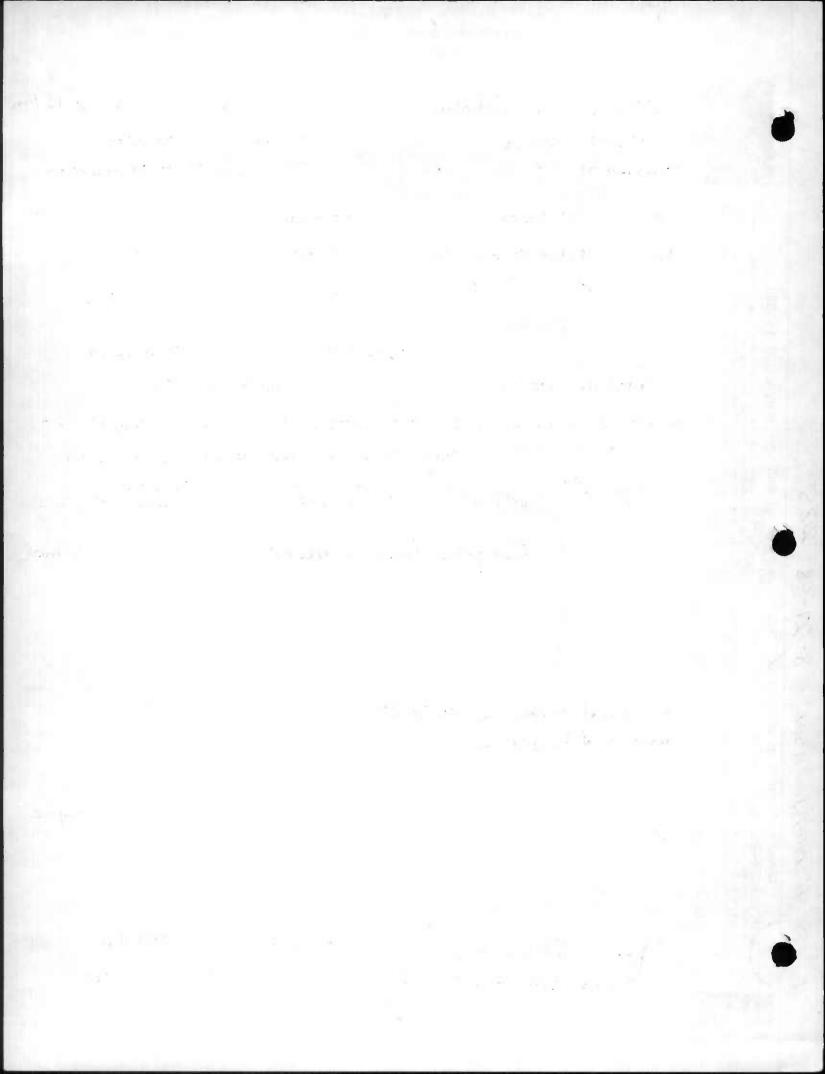
29a, Certifier (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

BIBBISON,

and 132 Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month 8/25/98 Day 8:45 PM ELTANUH D. JOHNSON 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death BALTIMORE N/A 5110 WOOLVERTON AVE. (HOME) If Under 24 Hrs. Birthplace (State or Foreign Country) MD If Under 1 Year 8. Date of Birth (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1□ M 2冊 F Months Hours Min 35 Yrs. MD. 216 92 1981 Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1# Yes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5110 WOOLVERTON AVE. 21215 USA 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1# Never Married 2 Married 1 ☐ Yes 2# No Specify: AFRO AMERICAN 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE DEPT. SEAR: S CO. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) WILBERT SEIGEL ESTELLE WHITE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ESTELLE WHITE MOTHER 5110 WOOLVERTON AVE. BALTO. MD. 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING:S PARK 8/31/98 RANDALLSTOWN, MD. 22. Name end Address of Facility ESTEP BROTHERS FUNERAL HOM 1300 EUTAW PL. BALTO. MD. 21. Signature of Funeral Service Licenses FUNERAL HOME e death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line CAN CETT BLADDER Immediete Ceuse (Final 18 MONTHS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy 211110 1 ☐ Yes 1 Tyes 2 DA 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

MD.

Director

Funeral

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Completed

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**Funeral** 

Director

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death

72 hours after

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23s or 28s-f show traumette event, the Medical Examiner must be notified at

permit. Pages 1 and 2 ahould be filled within Department of Health and Mental Hygione. Important: If Nem 27 is marked other than "s any injury or other traumetic event, the Med

physician the signed by I been si is certificate has to diractor, page 2 s

Physician/Medical Examiner

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Certification:

Medical

29a. Certifier

(Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 or Attending Physician: this After this death. Director: / To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

State Registrar 25. Was case referred to medical Other: 4 Nursing Home 5 PAesidence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medicat Examiner: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and plece, and due to the ceuse(s) end manner steted.

29b. Signatur and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

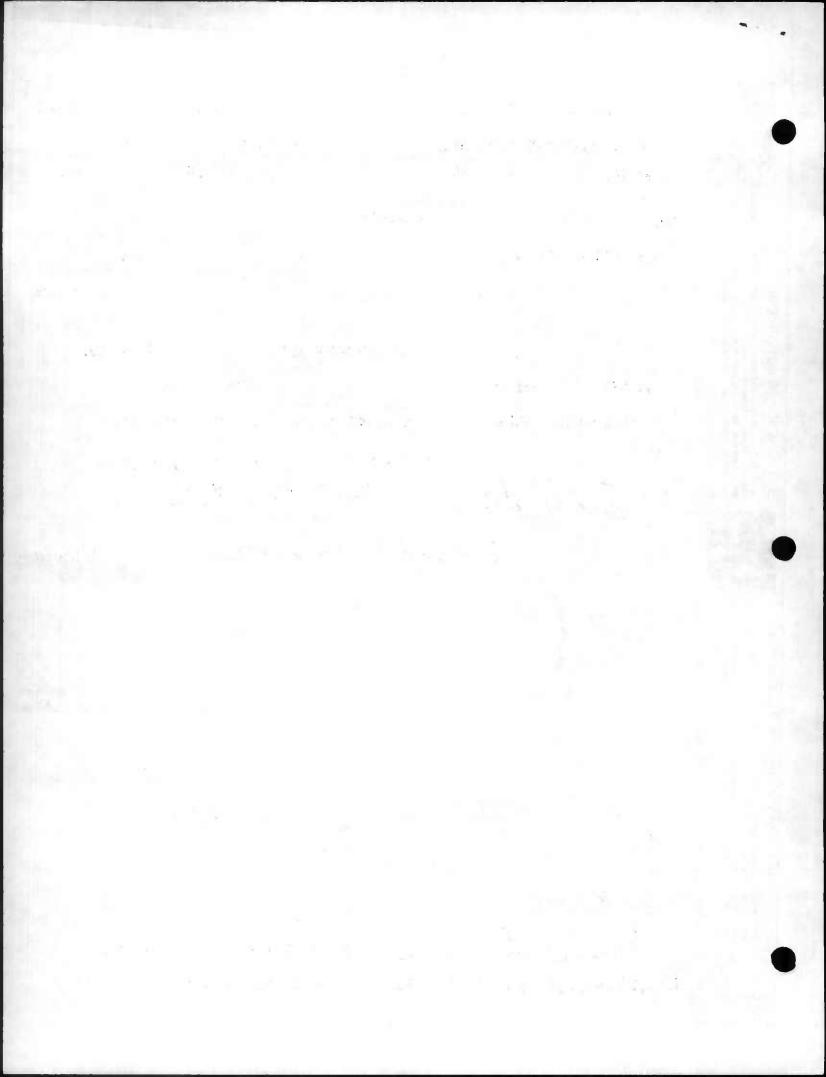
30 Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

ISHNAN

1998

305 BATIMONE MD 2120 NIEUTAW 84

32. Registrar's Signature



Pages 1 and 2 should be filed within 72 hours efter death with the Maryland

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mantal Hygiene. Important: if Item 27 is marked other than "natural", any Injury or other traumatic event, I'm Medical Execute.

Plea	se Type or P							II Copies Mental Hy					
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edent's Name (First, Middl	e, Last)							2. Dete of De		Day	Voor	3. Time of De	ath
Zedrick		Joh	nson	,Sr.				AUGUST	26	Dey 199	8	11:50	A
HCS, FORT H					T	FORT		ocation of Deet	1	4c. County			
al Security Number 5-54-1034		Age (In yrs. I	ast birthdey) Yrs.		eer eys	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 01-1	th IV. Ye	50	9. Birth	place (State or Fo	xeign
Residence of Decedent													
d NA			Town or Lo									10d. Inside City L	
reet end Number				10f. Zip Cod	de				10g.	Citizen of	Whet Cou	ntry?	
08 Homewoo	d Avenue			212	21	8			1	USA			
rital Status   Never Married 2	If Yes Give	es?		Was Decedent If Yes, specify (	Cub	dispanic Origan, Mexican  Specify:	gin? (Sp , Puerto	pecify Yes or No Rican, etc.)	)-		ck, White,	can indien, etc. ack	
	t's Education st grede completed)		(Give	dent's Usuel Oo kind of work do DO NOT use re	one	during most	of work	king	16b	o. Kind of B	usiness/in	ndustry	
entery/Secondary (0-12) th Grade	College (1-4	lor 5+)	Bur		31116	u)			M	aryl	and	Dry Do	ck
her's Neme (First, Middle,	Last)					18. Mothe	r's Nam	ne (First, Middle			ne)		
gar J	ohnson					Mary	7		Ja	cobs			
forment's Name/Reletions								rel Route Numb nue Ba				arylan	
ethod of Disposition  Burial 2 Cremetion  Donetion 5 Other (S	3 ☐Removel from Si	oto C	lece of Dispo	osition (Neme o	of ple	ce)		Date	200	. Location	- City or T	own, Stete Mo	đ

22. Name end Address of Fecility

the training the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, cause on each line.

Physician /Medical Examiner

attending physician end been signed by the s should be detached paga 2 s

certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funerel director,

Physician/Medical Examiner 2 Completed Be 2 Certification:

1. Decedent's

4e Fecility Ne

VAMHCS 5. Social Secu

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Usuel Reside

Md 10e. Street er 2108

11. Marital Str 1127 Never

3 Widow

Elementery llth 17. Fether's N

Edgar 19e Informer Mary 20e. Method 1 Buria 4 ☐ Done

21. Signature of Funerel Service Licensee

Immediate Cause (Final

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest

25. Was case referred to medical exeminer?

29b. Signature end title of certifier

1 Yes 2 No

27. Manner of Deeth

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 THomleide

diseese or condition resulting in deeth)

10e. State

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Be Completed

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Funeral

**Director** 

Division of Vital Records, P.O. Box 68760,

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	Reg	State gistrar

Medicai

31. Date filed (Month, Day, Year) SEP 1 1998

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6 Could not be determined

32. Registrer's Signeture Zeneva

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**MENINGITIS** Due to (or es e consequence of): ACOUIRED IMMUNE DEFICIENCY SYNDROME

Due to (or es e consequence of):

Due to (or as a consequence of):

Part II. Cities significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

PCP PNEUMONIA, CNS TOXOPLASMOSIS 5/98, HEPATITIS B & C

Hospitel: 1 Anpatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Dey Year) 5 Pending investigation

28b. Time of Injury

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated.

24e. Wes en eutopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Deeth (Check only one)

1 ☐ Yes 2 No

28d. Describe how Injury occurred

Baltimore, Maryland 21202

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably XXUnknown

Approximete intervel Between Onset end Deeth

WEIEKS

YEARS

24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

1 ☐ Yes 2 No

WM.C.March FH 1101 E. North Avenue

29c. License number

29d. Date signed (Month, Dey, Yeer)

ne end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 30. Name end eddress CUSTODIO, M.D.-9600 NORTH POINT RD, FT. HOWARD, MARYLAND 21052

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P. BUCHARIN CHANGE, A D. - SHAP BARIN A D.S. G. J. J. B. C. GROWN STREET

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 23part I, per M.D G-764 10/16/9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** KREMER 27, 1998 AUGUST 12:23am /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WINDSOR RIDGE NURSING HOME BALTIMORE BALTIMORE If Undar 1 Yaar If Undar 24 Hrs. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Months Deys Hours 1 M 2 □ F Yrs. 216-16-9858 JUNE 16,1921 BALTIMORE, MD Usuel Rasidence of Decedant

RANDALLSTOWN

10f. Zip Coda

**Funeral** Director

10a Stata

MARYLAND

10e. Street and Number

10h Count

BALTIMORE

with the Merylence rai', or items 23a or 28a-f shore Examiner must be notified at Director Funerai þ Completed

permit. Peges 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mantel Hygiane. Important: If Item 27 Is marked other than "natural", or Items 23. eny Injury or other treumatic event, its Medical Examine mail

/Medical Examiner

Baltimore,

certificate be executed physician end the bunal-tran Division of Vital Records. P.O. Box 68760. as ettending p The lew requires that the death signed by the e should I s certificate has b Attending Physician: this

**Physician** Examiner Physician/Medical ρ Completed Be Certification: To in 24 hours offer death.

A Fundred Director: After a being in a fundred by the fundred by the further and a fundred by the further further and a further furt edicai To the within 2

9311 SAMOSET ROAD 21133 12. Was Decedent Ever in U,S. Armed Forcas? 1∑ Yas 2 □ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 Nevar Married 2 Narried 1 ☐ Yas 2 ☑ No Specify. 3 Widowed 4 Divorced 16e. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada complated) (Giva kind of work dona during most of working lifa. DO NOT use ratired) Elemantary/Secondary (0-12) College (1-4or 5+) MEAT CUTTER
18. Mother's Name (First, Middle, Maiden Sumame) 12 17. Fathar's Nama (First, Middla, Last) NATHAN KREMER EFFIE 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) MRS. RENIE KREMER (WIFE) 9311 SAMOSET ROAD RANDALLSTOWN, MD 21133 20b. Place of Disposition (Nama of camatary, cramatory or other pleca) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Burial 2 Crametion 3 Ramoval from Stata RETH TFILOH 8-28-98 BALTIMORE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Address of Facility 21. Signature of Funeral Service Licensea SOL LEVINSON & BROS., INC. MMOT 8900 REISTERSTOWN ROAD PIKESVILLE, To not antar tha mode of dying, such es cardiac or respiretory errast, 23a. Part1. Enter tha disaasa, or complications that causad the shock, or haart failura. List only ona causa on each line. Immediata Ceusa (Final diseasa or condition rasulting in daath) ENAC FAILURE HYPERTENSION Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disaasa or injury that initieted avants rasulting in daath) Last Dua to (or as a consequence of)

Dua to (or as a consaquanca of):

10c. City. Town or Location

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Part II. Other algnificent conditions of	ontributing to death but not ra-	sulting in the underlyin	g causa givan in Part I.		23b. Did tobacco use co	ontribute to the cause of death?  3 □ Probably 4 □ Onknow
	T AND				24a. Was an autopsy performed?	24b. Wara autopsy findings eveileble prior to complation of causa of daeth?
					1 ☐ Yes 2 ☐ No	1 ☐ Yas 2 ☐ No
25. Was casa rafarrad to madical axaminar?			26. Plece	of Death (CI	heck only ona)	
1 Yas 2 No	Hospital: 1 ☐ Inpatiant 2 ☐	☐ ER/Outpatient 3☐	DOA Othar: 4 Nu	irsing Homa	5 ☐ Residance 6 ☐ Ott	her (Specify)
27. Manner of Daath Naturel 5 Pending 2 Accidant invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury et Work?		Describe how injury occu	rred
3 ☐ Suicida 6 ☐ Could not be determined	28e. Plece of Injury - At I building, atc. (Spec	nome, farm, street, fac	tory, office	28f.	Location (Street end Num. City or Town, Stata)	ber or Rurel Routa Number,

Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to tha causa(s) end menner es stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end menner stated. 29a. Certifian 29b. Signature and title of certifier

29d. Data signed (Month, Day, Year) 29c. Licansa number

ween

28595

10d. inside City Limits

10g. Citizan of What Country?

USA

FOOD

Race - Amarican Indien, Bleck, Whita, atc.

WHITE

COHEN

1 Yes 2 □ No

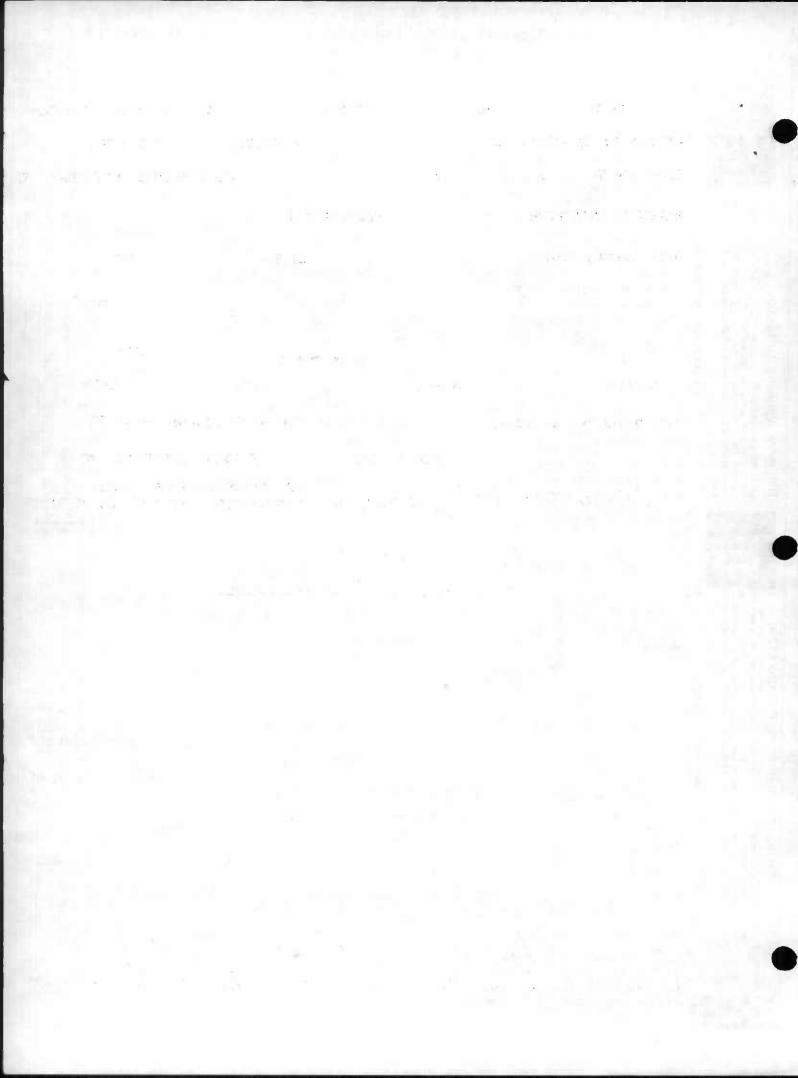
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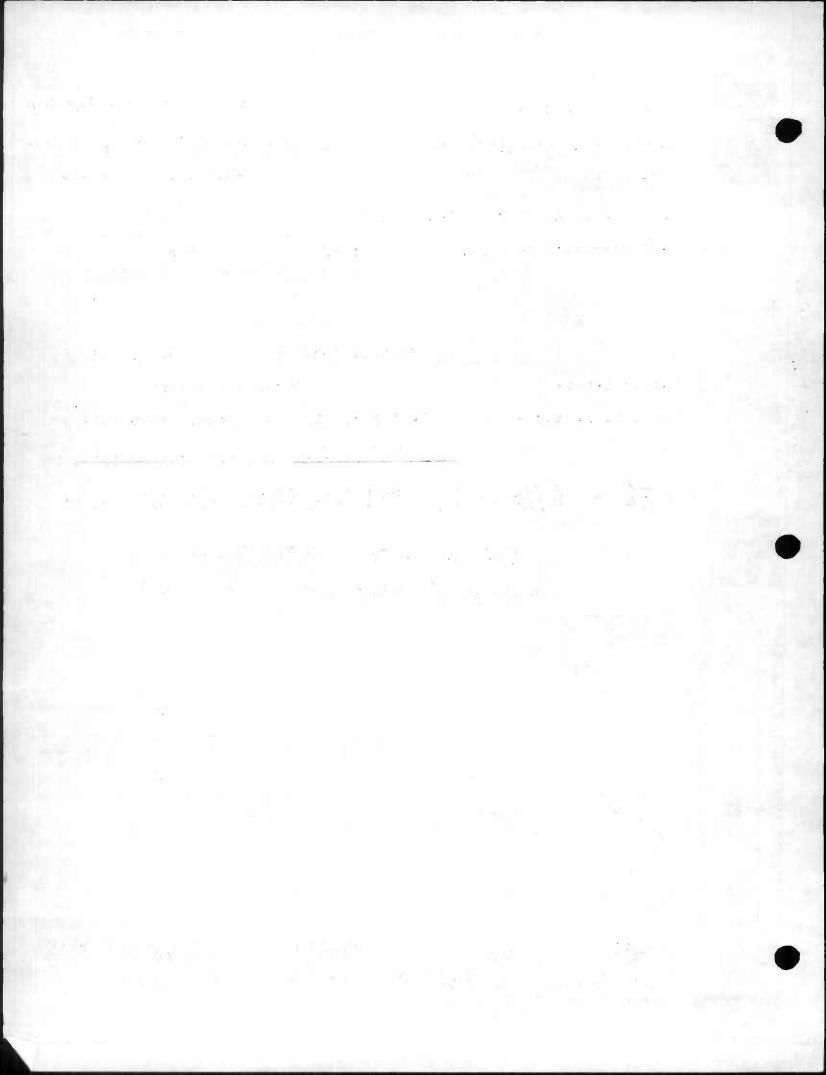
30. Nema and addrass of person who complated cause of death (Itam 23a) (Type, Print)

7220 PARK 1 ASNEEDO

31. Data filad (Month, Day, Yaar) SEP 1 1998 32. Ragistrar's Signetura



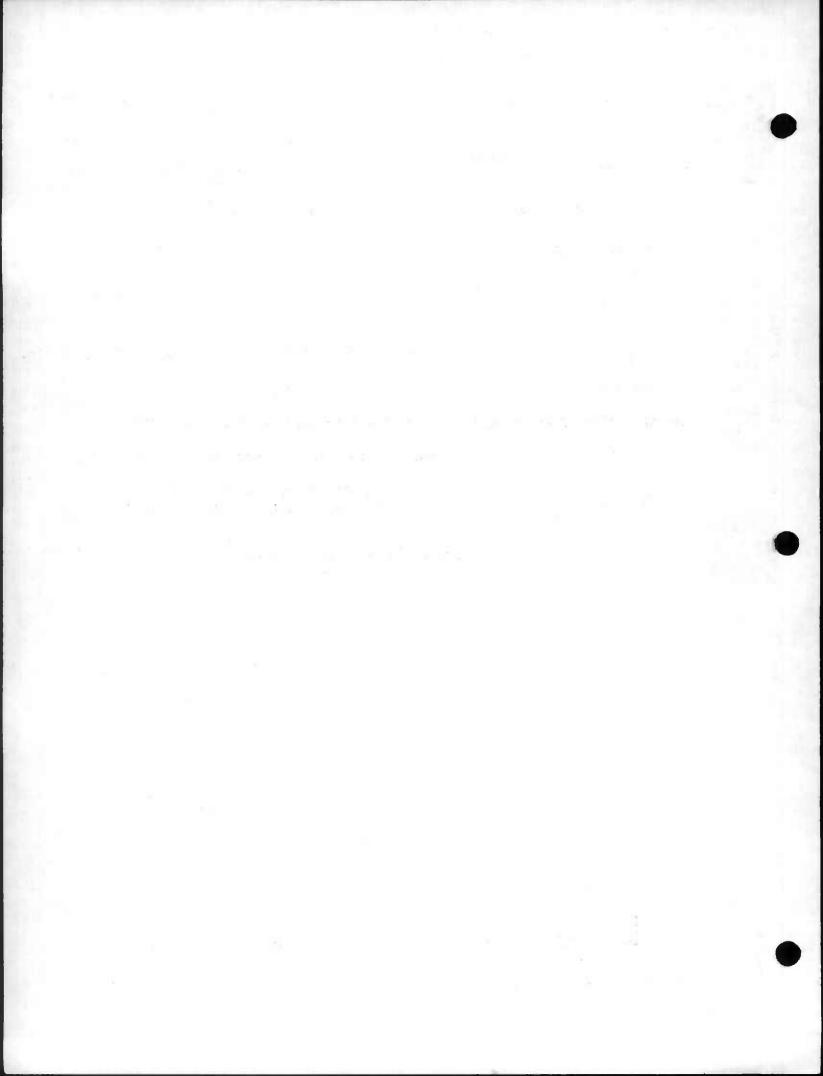
I to m # f	20h 20a nan FU 0762 0/11	State of Maryland	-	rtment of H tificate of I			giene Reg. No. 98	2663	8
	20b, 20c per FH G763 9/11, 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of [	
Physician '/Medical	Bernard W. Kru	ise				AUGUST	29	1998 1:301	A.m.
Examiner Funeral Director	4a Facility Name (If not institution, give:  NORTH RUND  5. Social Security Number  170–18–9766	EL HOSPITAL		If Under 1 Year Months Deys		. (Month, Da	ANN (	// 0	Foreign
	Usual Residence of Decedent  10e. State 10b. County		Town or Loc	ention		p direct	71310	10d. Inside City	
Maryla f sho	MD Anne Ar		ownsv					1 🗆 Yes	
frer deeth with the Manyland free deeth with the Manyland free crust De northed at Funeral Director	10e. Street and Number 1459 Fairfield	Loop Road		10f. Zip Code 21032	H.	- 1	10g. Citizen of W	fhat Country?	
15-0020 72 hours efter deet "neturel", or Herna 2 odical Examinet rru	1 Never Married 2 Married 3 Widowed 4 Sivorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	lf lf	Vas Dacedent of H Yes, specify Cuba ☐ Yas 212 No	ispanic Origin? (\$ in, Mexicen, Puer Specify:	Specify Yes or No rto Rican, etc.)		e - American Indian, k, White, etc.	
withir she.	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give I life. E	ent's Usual Occup- kind of work done of NOT use retired trol Op	during most of wo	orking	16b. Kind of Bu		
tal Hygid dother event, I	17. Father's Name (First, Middle, Last)		COII	cror op		me (First, Middle			1111
Y and Man Man To	Walter Kruise					nda Whe			
C = OI h	19a. Informant's Name/Relationship (Ty Banie K. Kruis							State, Zip Coda)210 nsville, M	
or Her roth	20a. Method of Disposition  p☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emovel from State 20b. Pla	ace of Dispos metery, cram	sition (Name of patory or other place no is Bethe CVeter	ans Cer	Date m. 9/1	Odenton	City or Town, State	ID ID
Demit. Page permit.	PSEUDO Dua to (or	Do not ente	uence of):  ANT ()	g, such as cardia	al Home Annap ac or respiretory a	rrest,	Approximate Interval Batw Onset and D	veen	
P.O. BOX 68/60, not the death certificete beat by the ettending physicials latached for use as the burn Physician Physician Medical E	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disaesa or injury that initiated evants resulting in death) Last	Due to (or	as a consequ	uence of):					
he dea the dea ched fo	Part II. Other aignificant conditions con	ntributing to death but not resul	lting in the ur	nderlying ceuse giv	en in Part I.		_/	ntribute to the cause of	
IS, P.O. I as thet the devigned by the e be datached for by Physic						. 10	Yes 20 No	3 Probably 4 □ U	Jnknown
s been s s should		1-1-10-				24a. Was	an autopsy ormad?	24b. Were eutopsy fin available prior to completion of ce of death?	
ta h age of or						10	Yes aUNo	1 🗆 Yas 2 🗆 I	No
Of VItal Physicien: T this certificat rel director, p	25. Was cese referred to medical examiner?	lospital:	-0.0	Oth	or:	eath (Check only			
o the state T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28b. Time of injury	28c. Injur	4 LI HUISHIY	Home 5 ☐ Resi 28d. Dascribe	how injury occur	11.27	
DIVISION C bit or Attending P s efter death. al Director: After it led in by the funere Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office	77.5	28f. Location ( City or To	Street and Numb wn, State)	er or Rural Route Numb	ber,
Hospi 24 hou Funer taly fill	29a. Certifier (Check only one) 16 Certifying Physical Examination (Check only one)	sician: To tha best of my knowner: On the basis of axaminati and manner stated.	rledga, daath on and/or inv	occurred at tha tin estigation, in my o	na, data and plac pinion, death occ	ea, and due to the curred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)	
To the within 2 To the comple	29b. Signature and title of certifier	YWA		29c. Licens	e number		29d. Dete signer	d (Month, Day, Year)	3
10	30 Name and address of person who co	201	1 Dr	Print).	n Bonn	i mo	Sid	01	
State Registrar	31. Date field (Month, Day, Year) SEP 1 1998	32. Registrar's Signati	ure 4	6-11	-1				
	OF1 T 1000	17.	v . /4	auks!					



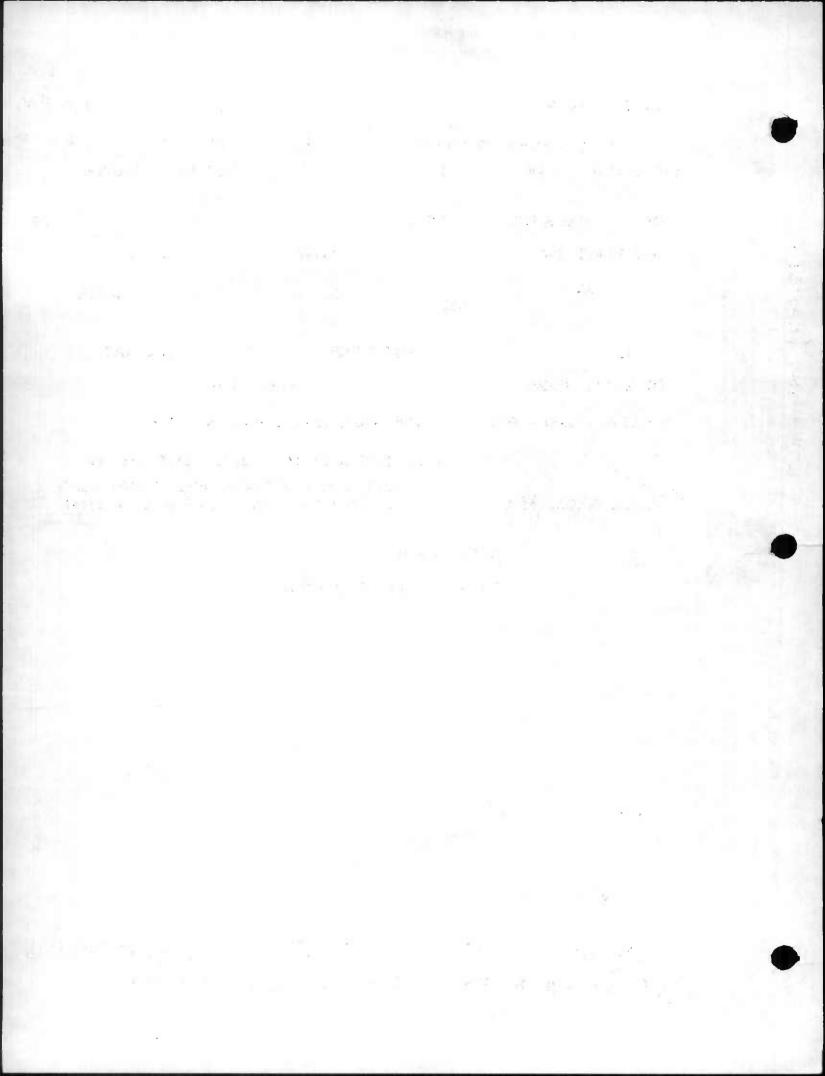
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** AUG. 1998 5:25pm BENSON LEE LANGUTH 30 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 138 Trailway Road Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | Month Day, Year | May 22, 1916 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** XXM 2□ F 212-03-4273 Yrs. 82 Director Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Md. Baltimore Middle River Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 138 Trailway Road 21220 USA items 23a Funerai 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Dependent of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or item any injury or other traumetic event, the Martine Example. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 X Divorced Completed 16e. Decedent's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Traffic Controler 12th Traffic&TransitBalto. 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be 2 unknown unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) KimberlyWileman/granddaughter 138 Trailway Road Baltimore Md. 21220 20b. Plece of Disposition (Name of cemetary, cramatory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State Metro Crematory Inc. 8/31/98 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore Md. 21. Signeture of Funeral Service Licenses 22. Name end Address of Facility Connelly Funeral Home of Essex 23a. Pert1. Enter the disease, or complications that caused the duals. Do not enter the mode or dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) i mo hetastatic Lung Examiner Due to (or es e consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed As hours effect death.

Annoral Director: After this certificate has been signed by the ettending physician and salely filled in by the furneral director, page 2 should be detected for use as the burlet resistance. Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Chack only ona) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 | Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Numbar or Rurel Routa Number, City or Town, Steta) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Spacify) 4 Homicide To the Hospital
within 24 hours e
To the Funeral C 1 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D45390 8131198 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) MYO MIN (IN . D.) G830 HOSPITAL DR. 205 # 37EHR BALTIMORE MD 21237 31. Dete filed (Month, Day, Yaar) 32. Registrer's Signature State 0 1 1998 Registrar



			Ce	rtificate o	Health and If Death		Reg. No.	8 26640
Physician /Medical	1. Decedent's Name (First, Middle, Last) FRANCIS M. LOWMAN					2. Date of Do	Dey	3. Time of Deeth
Examiner	4a Facility Name (If not institution, give some of the second of the sec	DEL HOST	ITAL	if Under 1 Ye	GLEN	SURVI	E AN	NE ARUNDE
Funeral Director	217-05-9754		yrs. last birthday) 7 8 Yrs.	Months Day			919°	9. Birthpiace (State or Foreig MARY LAND
they within 72 hours after death with the Maryland Hygiene. Hygiene. Indian than "naturel", or freme 23e or 28e-f show ent, it a Mexical Examiner must be northed at a Completed by Funeral Director.	Usual Residence of Decedent  10a. State 10b. County  MD ANNE AR	And the second second	SEVERN	ocation				10d. Inside City Limit
a or 28=fell	10e. Street and Number 8695 DOWNEY ROAD	)		10f. Zip Code	• 21144		10g. Citizen of U.S.A	
et, or items 234 Examiner must by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 X Xes 2 □ No If Yes, Give Yeer or Detes: Wi		Was Decedent of If Yes, specify C	of Hispanic Origin? uban, Mexican, Pu o Specify:	(Specify Yes or Nerto Rican, etc.)	o- 14. Rac Bia Specif	ce - American Indian, ck, White, etc. y: WHITE
nyglene. sther than "naturi ant, tre Mource! e Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Oct kind of work do DO NOT use ret	ne during most of w tired)	rorking	16b. Kind of B	usiness/Industry
S S S	17. Fether's Neme (First, Middle, Last) CHARLES N. LOWMA	N				ame (First, Middle SE ROTH	e, Maiden Surner	ne)
7 is me traum	19a. informant's Name/Relationship (Ty LOUISE B. LOWMAN				eet end Number or ROAD, SE			, State, Zip Code)
Depointant of need in important: if item 27 I any Injury or other tr. pnce.	20a. Method of Disposition  1 □ Surial 2 □ Cremetion 3 □ R  4 □ Donetion 5 □ Other (Specify)		Ob. Place of Dispo cemetery, cre		place)	Date 8/28		- City or Town, State
Medical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	pretions that caused the le cause on each line.  Preu I  Due  Aug 1  Due	MON/A to (or as a consecto (or as e consecto (or	quence of):	dying, such as cerd	w., Gilla	arrest,	Approximate Interval Between Onset end Deeth
by the ettending particle in the standard for the standar	Part II. Other eignificant conditions con	d	t resulting in the u	inderlying cause	given In Part I.		tobacco uea oc	ontributa to the causa of deat
has been sign ge 2 should be mpleted by						per	s an autopsy formed?	24b. Were autopsy findings available prior to completion of ceuse of death?
Be Be	25. Was cese referred to medical examiner?	lospital:			Other:	eath (Check only		_
her death. Itactor: After this In by the funeral di	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide	28a. Dete of Injury (Month, Day Yea  28e. Place of Injury - building, etc. (Sc		of 28c. In	njury at Nork? I ☐ Yes 2 ☐ No	28f. Location	how injury occur	
within 24 hours after To the Funeral Dir completaly filled in	29a. Certifier Certifying Physical Control (Check only one) 2 Medical Examination	siclan: To the best of my nar: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred at the evestigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the	e cause(s) end m	enner es steted. end due to the ceuse(s)
M M	29b. Signature and title of certifier	mo		29c. Lice	ense number		29d. Date signe	ed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 9 8 2664

Physician /Medical Examiner	1. Decedent's Neme (First, Middle			061	lineale	of Death		Reg. No.	
Examiner		ELEANO	R C.	LEE			2. Dete of D Month	Dey	3. Time of Dea 5.05 Pri
Funoral	4a Fecility Neme (If not institution  No. 14 Abunuary					-	own, or Location of Dec		
	5. Social Security Number 218–30–6680		ge (In yrs. las	t birthday)	If Under 1 \ Months D			Birth Day, 1919	9. Birthplace (State or Fo Mary 7 and
Director	Usuel Residence of Decedent	- X					pulle 4	, 1919	
28a-f show	Maryland Anne A	runde1		imore	cation				10d. Inside City Li 1 ☐ Yes 2
	10e. Street and Number 5902 Lynnbr	ook Road			10f. Zip Co 2122			10g. Citizen of V United	
5 E	11. Marital Stetus  1 Never Married 2 Merri 3 X Widowed 4 Divorced	12. Was Deceden Armed Forces ed 1 Yes 2 W tf Yes, Give Yeer or Detes:	? No		Ves Decedent Yes, specify		igin? (Specify Yes or f n, Puerto Rican, etc.) :		a - American Indian, sk, White, etc. : white
. 3	15. Decedent (Specify only highes	's Education t grede completed)		(Give I	ent's Usuel O kind of work o	one during mos	st of working	16b. Kind of Bu	usiness/Industry
r than	Elementary/Secondary (0-12)	College (1-4or		homem		эшгөа)		own h	ome
d out	17. Fether's Neme (First, Middle, Hugo Luedt	,					er's Neme (First, Midd dia Mangum		(e)
	19e. Informent's Neme/Reletions Walter S. Jones		aw		g Address <i>(S</i> <b>onair</b>		er or Rural Route Nun Baltimore		
nent of Health nt: If Itam 27 iry or other to	20e. Method of Disposition  W Burial 2 □ Cremation  4 □ Donetion 5 □ Other (S)		cerr	netery, crem	sition (Name natory or other	r place)	Sep. 2 1998		City or Town, State n Park, MD.
Department of Important: If I early or once.	21. Signature of Funeral Service	icenses					ak Funeral sco Avenue		more MD 21
ettending physician end if for use as the burkel-transit clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest	С.	Due to (or e	S e consequence s e consequence s	uence of):  WA .  uence of):	0			
the ettendir	Part II. Other signiticant conditio	0					I. 23b. D	d tobacco uee co	ntribute to the cause of c
ved by the deteche							1	yes 2□ No	3 □ Probably 4 ☑ On
ste has been signed by the ettend page 2 should be deteched for us Completed by Physician/				311			24e. W. pe	es en eutopsy rformed?	24b. Were eutopsy find eveileble prior to completion of caus of deeth?
page 2							10	Yes 2 No	1 □ Yes 2 No
this certificate ral director, pag	25. Wes case referred to medical exeminer?	Hospital:	iont 2DE	R/Outpetient	t 3□ DOA	Other:	e of Deeth (Check only		or (Specify)
on on	27. Manner of Deeth  1 Neturel 5 Pendin 2 Accident investig	28a. Dete of Inj (Month, D		8b. Time of Injury		Injury et Work? 1 Yes 2	28d. Describ	e how injury occur	11 11
effer deeth.  Director: Atte d in by the fune	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be ned 28e. Plecs of in building, e	njury - At hom tc. (Specify)	e, farm, stre	eet, fectory, o	fice	28f. Location City or 1	(Street and Numl Town, Stete)	per or Rural Route Number
d in defi	(Check only 2 Medical I	Physician: To the best examiner: On the basis and manner s	of examination	edge, death n end/or inv	occurred et t estigetion, in	ne time, date e my opinion, de	nd plece, end due to the time	ne ceuse(s) end me e, dete end place,	enner es steted. end due to the cause(s)
24 bours effective of Funeral Direction in the second control of t	one)				29c 1	cense number		29d. Date signe	
Within 24 pours effective to the Funeral Director Completely filled in Medical Cert	29b. Signature end title of certifier			AM	1	71 5 11	19	A	d (Month, Dey, Year)
Within 24 pours effe To the Funeral Dir completely filled in Medical Cert		who completed cause of	death (Item 2	3e) (Type, F	8	451	49	Aucus	24 -98

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State of Maryland / Department of Health and Mental Hygiene

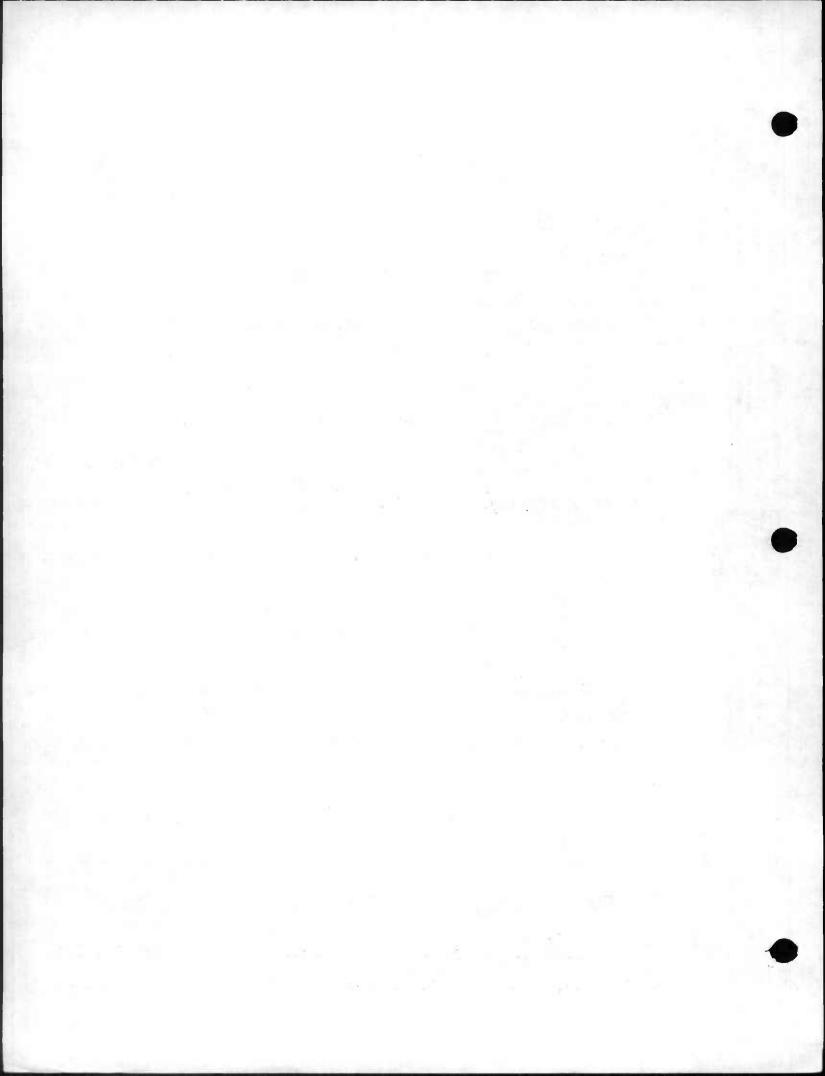
Certificate of Death Reg. No. 2. Deta of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Month **Physician** Wanda Opal Long August 25, 1998 8:00 am /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 918 Lance Avenue Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (Stata or Foraign
Country) **Funeral** Days Months Hours 1□ M 20 F 214 22 1085 Yrs. 76 6, Director May 1922 West Virginia Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2 No Director Essex 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death with 918 Lance Avenue 21221 USA Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filled within 72 hours after intent of Health and Mertal Hygiene.

Anti fillem 27 is marked other than "natural, or the mry or other traumals avent, the Medical Empire my or other traumals avent, the Medical Empire my 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electronic Technician Aerospace altimore, Maryland 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) 8 Cecil R. Jefferies Amy Mahone 19a. Intormant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandy Lucky (Daughter) 918 Lance Avenue Baltimore, Md. 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If eny injury or 5 ☐ Other (Specify) 4 Donetion Holly Hill Mem. Gardens 8/27/1998 Baltimore Co., Md. 21. Signature of Funeral Service Ucensee 22. Nama and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 onm DUTKOUD and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, nock, or heart tailure. List only one cause on each line. Approximata Intervel Batwe Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) NON-SMALL CELL CARCINOMA OF THE LUNG 2 YRS. Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Records, P.O. Box 68760 Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? È 1525 os 2 No 3 Probably 4 Unknown Hypertension signed b à 24b. Were autopsy tindings available prior to completion of causa of death? Completed 24a. Was en eutopsy performed? Arteriosclerotic Cardiovascular Disease The law 1 Yas 2X No 1 ☐ Yas 2 ☐ No Vital 25. Was case refarred to medical examiner? 80 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa SIX Rasidance 6 Othar (Specify) Certification: To 1 Yes 2 No ö 결 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, term, street, tactory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the tima, data end place, end due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, daath occurred et tha time, data end place, and dua to the causa(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) D17728 August 26, 1998 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto., MD 21236 8022 Belair Rd. Ba Yin Oung, M.D. 31. Date filed (Month, Day, Year)

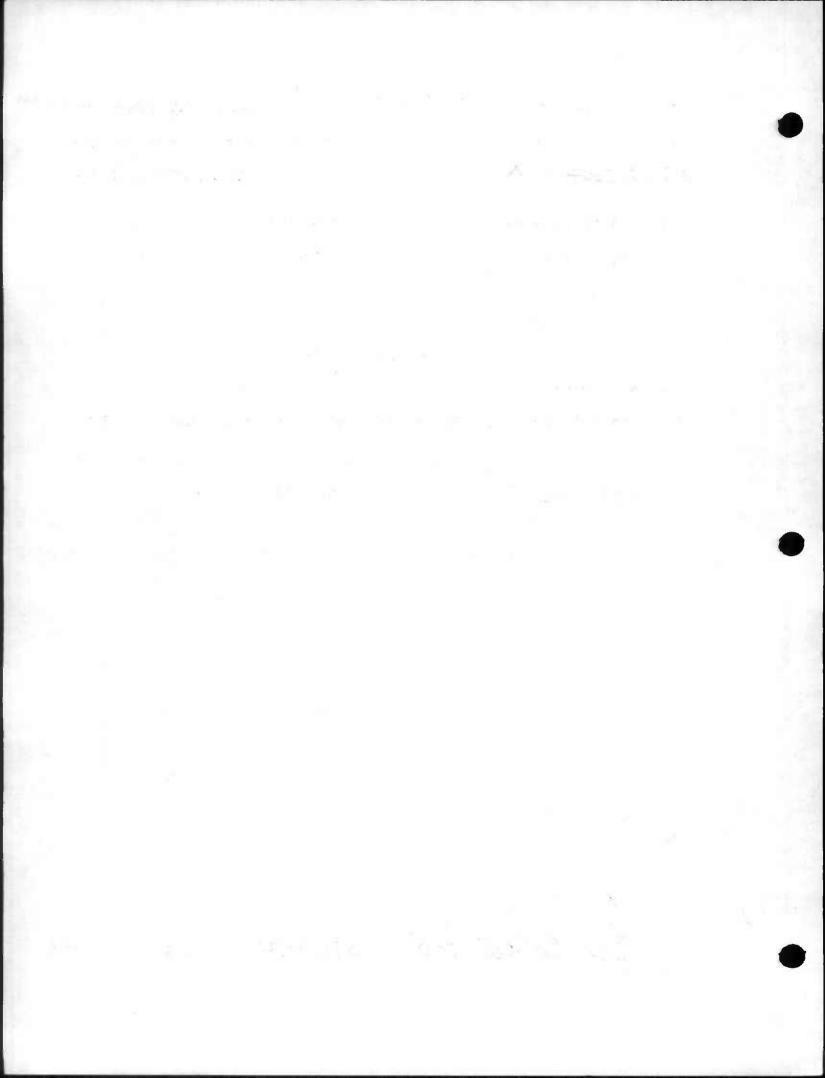
**DHMH 16 Rev 6/95** 

State Registrar 32. Registrar's Signeture

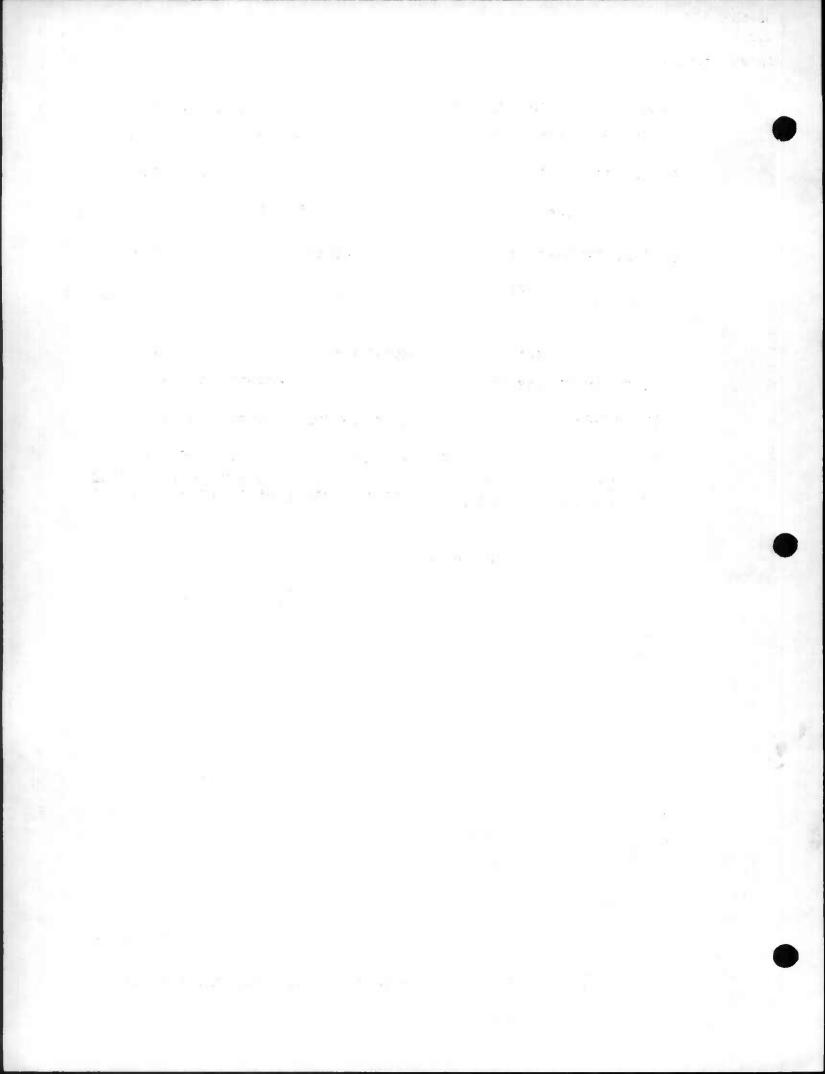


State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Neme (First, Middle, L	ast)				100	2. Dete of De		3.	Time of Death
Physic /Medi		ELIZABE	TH	LAPO	ORTE			AUG.	30 19	198	4:53 AN
Exami		4e. Fecility Neme (If not Institution, ga	ve street and number)				b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
		286 North Dr	ive			9	Severna	Park	Anne	Arund	el
Funeral Director			1 DM 2DKF	In yrs. lest birth	rs. If Und	er 1 Yeer	If Under 24 Hrs. Hours Min.	8. Dete of Bird (Month, De JAN 01	th y, Year)	9. Birthpiece Country)	(Stete or Foreign
yland		10a. Stete 10b. County	1	Oc. City, Town	or Location					10d. I	nside City Limits
deeth with the Maryland rms 23a or 28a-f ahow rmant or notified at	ctor	MD Anne A	rundel		5	Sever	na Park	C		1	☐ Yes 2 No
라 다 다 67 28	- E	10e. Street end Number			10f. Z	ip Code			10g. Citizen of V	Vhet Country?	
23a	Ta I	286 North Driv	ve			21	146		US	SA	
5 2 3	by Funeral Director	11. Maritel Stetus  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ev. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		13. Wes Dece If Yes, sp		ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Reco	e - American Ir k, White, etc. White	
n 72 "nat	Completed	15. Decedent's E (Specify only highest gi	ade completed)	18e. I	Decedent's Us (Give kind of w life. DO NOT	uei Occupi rork done d use retired	etion furing most of work )	ing	16b. Kind of Bu		
be filed within tal Hygiene. Id other than "event, the War	mo	Elementery/Secondery (0-12)	College (1-4or 5+)		ttleme	ent (	Clerk		Real E	Estate	
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should be filed vend Mantal Hygie smarked other tumetic event, in	To	Joseph Thompso	on				Mary 1				
U		19e. Informent's Name/Reletionship					and Number or Rur				
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pemit. Pages 1 and Depertment of Haalth Important: If Item 27 any Injury or other to once.		20a. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 [		cemetery	, cremetory or	other piec	,	Dete	20c. Location -	219 300 113	
permit. Pa Depertmer Important: any Injury		4 ☐ Donetion 5 ☐ Other (Special Signetus Service Lice		Metro	Cremate	9 -	Inc. U	8/31/98	Baltin	nore,	MD
permit. Page Department of Important: If any Injury or		Edward A	Regorchik		Crema 299 F	rede	Societ	oad Bal	Ltimore	. MD	21228
		23e. Pert1. Enter the disease, or co- shock, or heert failure.	pplications thet caused the one cause on eech line.	e death. Do n	ot enter the mo	ode of dyln	g, such es cardiac	or respiretory e	rrest,	App	proximete prvel Between
/Medical Examiner	Examiner	Immediete Cause (Finel disease or condition resulting in deeth)	D	ue to (or es e c	onsequence of	):	REAST	CAI	NCER	3	YEARS
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that the daeth cert ed by the attending detached for use	Physician/N	Pert II. Other significant conditions	contributing to death but r	not resulting In	the underlying	cause give	en in Pert I.				cause of death?
signed by	by Pt							10	Yes 200 No	3 Probably	y 4 ☐ Unknown
- D 0	Completed b							24a. Wes perfo	en eutopsy rmed?	eveilab	utopsy findings le prior to tion of cause h?
ysician: The law is certificeta hes b director, pege 2 s	S							101	res 2 No	1 □ Ye	s 2 No
clan: ertific ector,	Be	25. Was case referred to medical examiner?				Lau	26. Place of Deet	h (Check only o	ne)		
두 등 등	2	1 ☐ Yes 2 No  27. Meaner of Deeth  1 Neturei 5 ☐ Pending	28a. Dete of Injury (Month, Dey Y	2 ☐ ER/Out 'ear) 28b. Ti		28c. Injury Work	4 LI Nursing Ho		dence 6 Other		
or Attending Mar death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not 1 4 Homloide determined	On Dines of Initial	- At home, fen				28f. Location (S City or Tox	Street end Numb vn, Stete)	er or Rurel Ro	ute Number,
Pours y		29a. Certifier for Certifying Pl	nysician: To the best of n	ny knowledge,	deeth occurred	d et the tim	e, dete end plece,	end due to the	cause(s) end me	nner as steted	
n 24 Plata	Medicai	one)	miner: On the besis of ex end menner stete	d.	or investigetio	n, in my op	oinion, deeth occur	red et the time,	dete end place, (	and due to the	COUSO(S)
2 2 2 2	2	29b. Signature end of certifier	00 -	4. 0	25	9c. License			29d. Date signed	i (Month, Dey,	Year)
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	1. Decedent's Name (First, Mid	ddle I an	11			Certifica	210 01	Doutin	2. Date of D	Reg. No.	1	3. Time o	f Death
an	A William Control of the Control of								Month	Day	Yeer	S. TITTIE O	Death
al	CHARLES  4e Fecility Name (If not institu		JCE MI					4h City Town	AUG. or Location of Des	26, 1991 th 4c. County		060!	5 AM
er	2412 EAST FE							BALTIN		N/			
	5. Social Security Number	6. Se	ex	7. Age (In	yrs. lest bir		der 1 Year					ece (Stete	or Foreign
	216-44-2098 Usual Residence of Decedent		₽M 2□ F			Yrs. Month	ns Days	Hours M	lin. 8. Date of B (Month, D JAN 2	6, 1944	Count	MD	
	10a. State 10b. Cour			10	c. City, Tow	n or Location					10	d. Inside C	ity Limits
to	MD	N/A						BALT.	IMORE			¹∕Ū Yes	2 🗆 No
Funeral Director	10e. Street end Number					101.	Zip Code			10g. Citizen of	What Count	ry?	
a D	2412 E. FED	ERAI	ST				212	13		U.S.A	A .		
ner	11, Maritel Status		12. Was De Armed F	cedent Ever	r in U,S.	13. Was De	cedent of h	dispanic Origin?	(Specify Yes or Nerto Rican, etc.)	lo- 14. Rac	ce - America		
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ted	15. Deced	lent's Edu	ucation	.0	16a.	Decedent's U	sual Occup	petion	unding	16b. Kind of B	usiness/Ind	ustry	
Completed	(Specify only high			(1-4or 5+)		life. DO NOT	use retire	oetion during most of a d)	WOIKING				
Con	9th	1	V/A		U	NEMPLO	OYED	,		N/A			
Be	17. Fether's Name (First, Midd		0.337 -	D					Name (First, Middl		ne)		
0	HEZEKIAH			K					THER WA				
	19a. Informant's Name/Relation		ype, Print)		1				Rurel Route Num			Code)	
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	20a. Method of Disposition 1 → Burial 2 □ Cremation	n 3 🗆 F	Removel from	m State	cemeter	y, cremetory o	or other ple	ce)	Date	20c. Location		vii, State	
	4 Donetion 5 □Other			N	MT. Z	ION C			9-3-98				
	21. Signature of Fuheral Servi	ce Licens	see :4	Betto					BETTS F E ST BA	UNERAL			
	23a. Part1. Enter the disease, shock, or heart failure. L	or comp	licetions thet	t caused the	deeth. Do							Approxime	te
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 6976

## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

TOSHIO D. MADDUX  # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location of Death # A Colly, Torm, or Location # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location of Death # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, or Location # A LOTY, Torm, I	1. Decedent's Name (First, Middle	ile, Last)						2. Dete of De	Dev	Year	3. Time of De
Social Security Number    Social Security Number Number   Social Security Number Number   Social Security Number Number   Social Security Number Number Number   Social Security Number Numbe	TOSHIO D.	MADDUX									0008
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Title   Internate   Internation   Internat				V	Months Dey	s Hours					
MD N/A BALTIMORE  10/2 Fe Code  10/2 Fe Code  11/2 Fe Code			10.00	7			-				
10. Street and Number  48.14 HAMILTON AVENUE — 3D  10. Ze Gode  10. Cellson of What Country?  11. Merital Satus  12. Was Declared Even in U.S. Amend Control of Street Amend C			10c. City	y, Town or Lo						1	
4814 HAMILTON AVENUE - 3D  11. Marinal Status  12. Was Desident Ever in U.S.  13. Wes Desident of Hispanic Crigin' (Seady Yes or No. 11 Cifes 2010)  11. Was Desident of Hispanic Crigin' (Seady Yes or No. 11 Cifes 2010)  11. Was Desident of Hispanic Crigin' (Seady Yes or No. 11 Cifes 2010)  12. Specify: Specify Clearly  13. Desident of Experiments (Seady Yes or No. 11 Cifes 2010)  14. Specify: Specify Clear or No. 11 Cifes 2010  15. Desident (Seady Yes or No. 11 Cifes 2010)  17. Father's Name (First, Modde, Last)  18. Marchad Objection  19. Informer's Name (First, Modde, Marchad Number or Plausi Route Number. Cify or Town, Stee, 2010)  19. Informer's Name (First, Modde, Marchad Number or Plausi Route Number. Cify or Town, Stee, 2010)  19. Informer's Name (First, Modde, Marchad Number or Plausi Route Number. Cify or Town, Stee, 2010)  19. Marchad Objection  XX Sharid 2 Commission 3 Demonstration State 4 (Donation 3 (Donation State 4 (Donation 3 Demonstration State 4 (Donation 3 (		'A			1				40- OW		- V
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10   New Married     Married     Married				\$ 13			igin? (Spec	ifv Yes or No			can Indian.
3 Wildowed 4 Divorced Year o' Dates:    10		Armed Fo	orces?		If Yes, specify Cu	iban, Mexica	n, Puerto F	lican, etc.)			
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Elementary/Secondary (0-12)   College (1-40-5+)   BARBER   HATR   17. Father's Name (First, Middle, Maidlen Sumame)   MONET MADDUX   MONET MADDUX (MOTHER)   199. Mailing Address (Great and Number or Putal Rode Number, City or Town, Stein, Zip Code)   MONET MADDUX (MOTHER)   199. Mailing Address (Great and Number or Putal Rode Number, City or Town, Stein, Zip Code)   MONET MADDUX (MOTHER)   199. Mailing Address (Great and Number or Putal Rode Number, City or Town, Stein, Zip Code)   MONET MADDUX (MOTHER)   199. Mailing Address (Great and Number or Putal Rode Number, City or Town, Stein, Zip Code)   MONET MADDUX (MOTHER)   20c. December of Special Number or Putal Rode Number or Putal Rode Number, City or Town, Stein, Zip Code)   MONET MADDUX (MOTHER)   20c. December of Special Number or Putal Rode Number or Putal Rode Number or Putal Rode Number or Putal Rode Number or Putal Rode Number or Putal Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Number or Rode Rode Number or Rode Number or Rode Rode Number				16a. Dece	dent's Usual Occ	upation	a ad mandelin		16b. Kind of	Business/In	dustry
17. Father's Name (First, Middle, Last) ROGES STURDIVANT ROGES STURDIVANT 18e. Informent's Name/Feletionship (Fype, Print) NONET MADDUX (MOTHER) 4814 HAMILTON AVENUE—30—BALTIMORE, MARYLAND 21: 20a Method of Disposition XXBurial 2   Corenation 3   Removal from State 4   Concation 5   Concentration of State 5   Concentration of State 6   Concentration of State		1		life.	DO NOT use reti	ired)	SE OF WORKIN	9			
ROGES STURDIVANT  19b. Informent's Name-Felestionship (Type, Print)  MONET MADDUX  MONET MADDUX (MOTHER)  20a. Method of Disposition  XXBurial 2 Corenation 3 Removal from State  4814 HANTITON AVENUE—30—BALTIMORE, MARYLAND 212  21. Signature of Funeral Service Licensee  XIS grature of Funeral Service Licensee  Approximate o					BARBER				H	AIR	
19e. Informent's Namer/Reletionship (Type, Print)  MONET MADUX (MOTHER)  20a. Method of Disposition  XSDurial 2 Commention 3 Removal from State  4 Donation 5 Donate (Specifix)  4 State HAMILTON AVENUE—3D—BALTIMORE, MARYLAND 21:  20b. Method of Disposition Maryland of Disposition (Maryland of Disposition)  XSDurial 2 Commention 3 Removal from State  4 Donation 5 Donate (Specifix)  4 State HAMILTON AVENUE—3D—BALTIMORE, MARYLAND 21:  20b. Exercise (Print)  4 State HAMILTON AVENUE—3D—BALTIMORE, MARYLAND 21:  21 Signature of Thoraral Service Loansee  22. Namer and Address of Facility  BALTIMORE, MARYLAND 21:217—17:21—27 N. MONROE  23e. Part. Effect the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory areast, infection of the printing of deeth)  1 Immediate Cause (Final disease or conditions, a part is provided by the printing of deeth)  1 Due to (or as a consequence of):  2 Due to (or as a consequence of):  2 Due to (or as a consequence of):  2 Due to (or as a consequence of):  2 Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.  2 Due to (or as a consequence of):  2 Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.  2 Due to (or as a consequence of):  2 Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.  2 Due to (or as a consequence of):  2 Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.  2 Due to (or as a consequence of):  2 Sequentially list conditions contributing to deeth but not resulting in the underlying cause given in Part I.  2 Due to (or as a consequence of):  2 Sequentially list conditions contribution to medical cause of high list of the cause of list of list of the cause of list of list of list of list of list of list of list of list of list of list of list of list of list of list of list of list of lis									, Maiden Surn	ame)	
MONET MADDUX (MOTHER)  4814 HAMILTON AVENUE—3D—BALTIMORE, MARYLAND 21:  720s. Method of Disposition	ROGES STU	JRDIVANT									
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**XRBurial 2 Cremation 3 Removal from State 4 Donation 5 Chorer (Specify)  **REMORIAL PARK 9/3/98 BALTIMORE, MARYLAN  21. Signature of Funeral Service Licensee  **22. Name and Address of Facility  **ELIZABETH L. PHILLIPS, P.A.*  **BALTIMORE, MARYLAND 21217-1721-27 N. MONROE  23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for the disease or condition.  **Immediate Cause (Final disease or condition resulting in death) List only one cause or each line.  **Due to (or as a consequence of):  *		(MOTHER)				N AVEN	UE-3D				
22. Name and Address of Facility  ELIZABETH L. PHILLIPS, P.A.  BALTIMORE, MARYLAND 21217-1721-27 N. MONROE  23a. Part Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest flating. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Last only one cause on each line.  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  23b. Did tobacco use contribute to the cause of the third of the deeth		3 Removal from	C	am <i>etery</i> , cre	matory or other p	olaca)	1				
BALTIMORE, MARYLAND 21217-1721-27 N. MORROE  23. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shock, or heart failure. Left only one cause on each fine.  Approximate consisting in death)  Due to (or as a consequence of):  24a. Was an autopsy for exclusion from entering the exclusion of death)  Due to (or as a consequence of):  25. Was case referred to medical examiner?  10 Yes 2 No 3 Probably 4 Yes  24a. Was an autopsy for exclusion from entering the examiner?  10 Yes 2 No 3 Probably 4 Yes 2 No 3 Probably 1 Yes 2 No 3 Probably 1 Yes 2 No 3 Probably 1 Yes 2 No 3 Probably 1 Yes 2 No 3 Probably 1 Yes 2 No 3 No 1 North Individual Science of Control of the Science of Control of the Science of Control of the Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of Control of North Individual Science of North Individual Science of North Individual Science of North Individual Science of North Individual Science of North Individual Science of North Individual Science of Nor			KIN					3/98	BALTI	MORE,	MARYLAI
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29a. Certifier (Check only one) 29b. Signature and title of cartifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last  Part II. Other significant conditions.	a. M. d.	Due to (or Due to hot results)	or as a consecutive as	quence of): quence of): quence of): quence of):	given in Part	W. I.	23b. Did 1 24a. Was perf	tobacco use (Yee 2 No	24b. W	o the cause of bably 4 Urer autopsy fin reliable prior to mpletion of cau death?
29a. Certifier (Check only one)  29b. Signature and title of cartifier  29b. Signature and title of cartifier  29c. License number  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Part II. Other significant conditions are summer?  1 XXes 2 \( \subseteq \text{No} \)  27. Menner of Deeth	a	Due to (or Due to (or Due to hour not result in the land of the la	or as a consecuta as a consecutar as a consecu	quence of): quence of): quence of): quence of): quence of):	given in Part  26. Plac  Other: 4 \( \text{N} \)	U.  I.  e of Death ursing Hon	23b. Did 1  24a. Was perf	tobacco use of tobacc	24b. Wey co	o the cause of bebly 4 Urer autopsy fin reliable prior to mpletion of cal death?
29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as steted. (Check only one)  1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as steted. (Check only one)  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of cartifier  29c. License number  O.C.M.E.  AUGUST 29, 1998	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last  Part II. Other significant conditions are summer?  1 XX es 2 No  Note that the significant conditions are summer?  1 XX es 2 No  To Menner of Deeth  1 Natural 5 Penditions	a	Due to (or Due to (or Due to hour not result in the land of the la	or as a consecutive as	quence of):  quence of):  quence of):  quence of):  underlying cause	given in Part  26. Plac  Other: 4   N	I. e of Death ursing Hon	23b. Did 1  24a. Was perf	tobacco use of tobacc	24b. Wey co	o the cause of bably 47\$U  /ere autopsy fire reliable prior to mpletion of cal death?
(Check only cone)  29b. Signature and title of cartifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Year)  AUGUST 29, 1998	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last  Part II. Other significant conditions are summer?  1 XX es 2 No  27. Menner of Deeth  1 Natural 5 Pendir investical solutions of Could	a. M.  b	Due to (or  Due to	or as a consector as	quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):  quence of):	given in Part  26. Plac Other: 4 N	I. e of Death ursing Hon	23b. Did 1 24a. Was perf  (Check only the 5 Beschibe St. Location 8f. Location 18f. Lo	tobacco use of tobacc	24b. We con of the control of the co	o the cause of babbly 4750 fore autopsy fin reliable prior to ampletion of cardeath?  Yes 2 \( \) \( \) \( \) \( \) \( \) \( \)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #26 Per MD Film G763 9-1-98RC Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1500 km Norman W. Moseley, Sr. 28,1998 August /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N. Ellwood Ave. Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) 9. Big March 27,1916 ff Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days TOTAL OF F 82 Yrs 227-07-1192 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits XX es 2 No MD n/a **Baltimore** Director or 28a-f 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 238 1507 21213 N. Ellwood Ave. **USA** Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 XX s 2 No
If Yes, Give
Year or Dates: WWII 8 Specify: Black Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: **XX**Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry t be filed within 7 rital Hyglene.
ad other than "n. event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) 9th Mail Deliver Bethlehem Steel 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Marital Hy
Important: If Illem 27 is marked other any injury or other traumetic event Be Wesley Moseley Nora Morton 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) Elsie Mason/daughter 1507 N. Ellwod Ave. Balto., MD 21213 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Va Cem 9/2 Owings Mills, MD 22. Name and Address of Fecility

James A. Morton & Sons Funeral Home Signature of Funeral Service Licenses 1701 Laurens St. Balto., MD 23a. Pagt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical · 10 years Examiner Due to (or as e consequence of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medicat Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ERVOutpatient 3 ☐ DOA 1 Yes 2 No Certification: To # 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? if or Attending P stiller death. 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Ptace of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide hours / 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 9 å 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) August 31,1998 RBS DOU

State Registrar

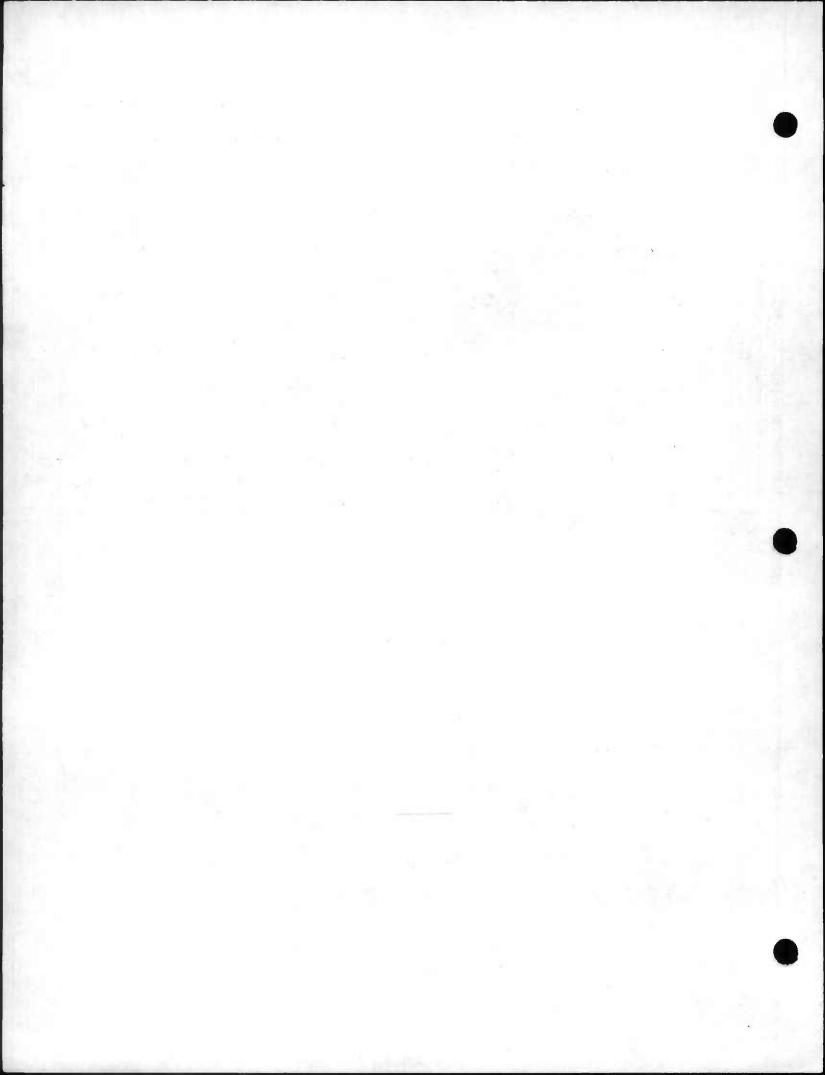
31. Dete filed (Month, Day, Year) SEP 0 1 1998

ROSS

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Summen 32/Registrar's Signature

MD

Walfe Street By Hour Maryland 21287



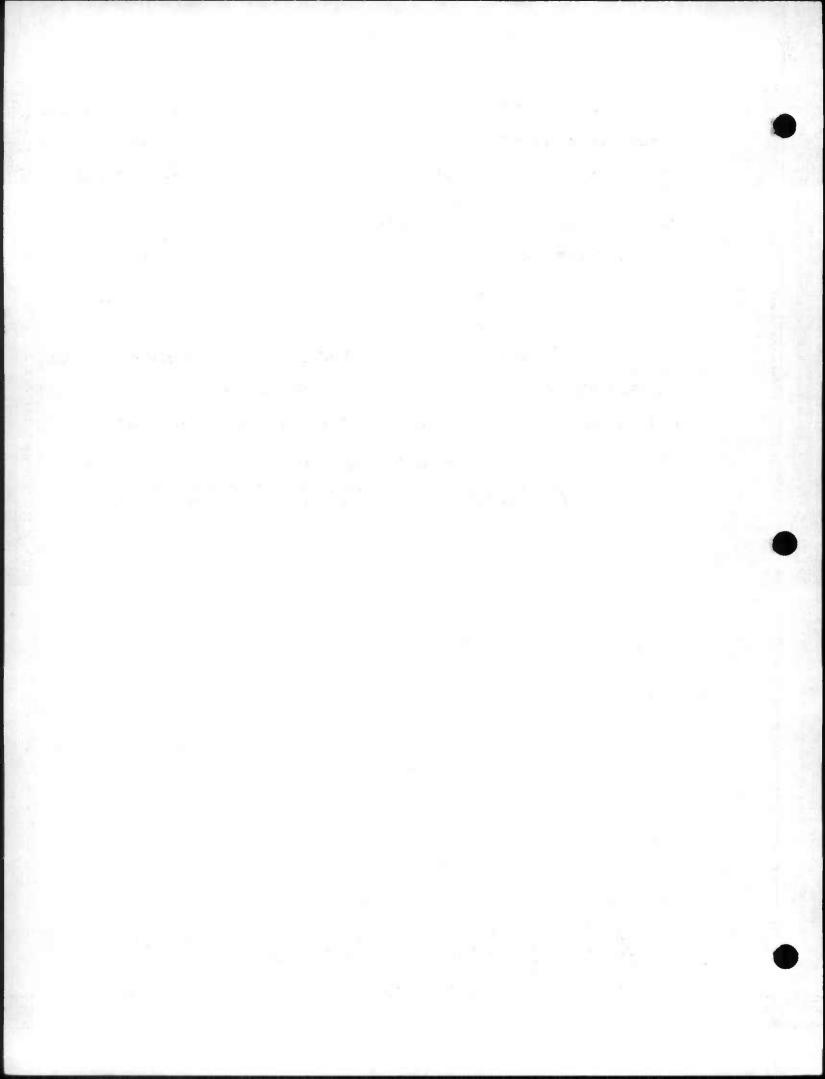
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** ROSALIE MORGAN AUGUST 26, 1998 12:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecliity Neme (If not institution, give street end number) Examiner CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) if Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 5. Sociel Security Number **Funeral** Months 1 M XXF Deys Yrs 219-16-8625 75 JUNE 8, 1923 MD Director Usuel Residence of Decedent the Maryland 10d. Inside City Limits r 28a-f show 10e Stete 10b. County 10c. City, Town or Location 1 Yes 2 No Directo BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 7 is marked other than "natural", or frame 23a or traumatic event, the Medical Examiner must be a 601 EARLTON COURT 21136 U.S.A. Funeral Pagas 1 and 2 should be filed within 72 hours aftar death ment of Haalth and Mental Hygiana.
Int: If Item 27 is marked other than "natural, or Items 23.
Iry or other traumatic event, the Madical Examinations in the madical Examinations. 14. Rece - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest g rede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be GOLDEN **JOHN** MILDRED LIPSITZ 0 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) JOHN MARTALO (NEPHEW) 2 HOMESTEAD DRIVE #C OWINGS MILLS, MD 21117 Saltimore, 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Durial 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) permit. Page Department of Important: If any injury or DRUID RIDGE CEMETERY 8/28/98 PIKESVILLE, MD 22. Name end Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. llensue 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused find that 1. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Metastatre of stomach adeno car un oma 1 year Examiner Due to (or es e consequença of): Examiner physician and the bunal-transit tha death cartificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of) 50 attanding usa 23b. Did tobecco use contribute to the cause of death? ad by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert II. 3 □ Probably 4 Ø Unknown 1 | Yes 2 | No. signad t of Vital Records, g 24b. Were eutopsy findings eveilable prior to been si 24e. Wes en eutopsy Completed completion of cause of deeth? cartificata has t 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funarai 27. Manner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Division of Hospital of Attending P 1 Z Naturet 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner steted. (Check only one) To the I vithin 2 To the I complain 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier MD D 35844 27 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 21117 D Roggen 21 Crossroads Drive Owngs mills MD 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signature 1998 State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Tima of Death Month **Physician** HAYWOOD 29, 1998 AUG. 2:30AM /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Days Hours Min. (Month, Dey, Year) 5. Sociei Security Number 6. Sax 7. Age (In yrs. last birthdey) Birthplaca (Stete or Foreign Country) **Funeral** Months 1□ M 2□ F Yrs. 230-10-7878 Director 13,1921 VIRGINIA Usual Residence of Decedant the Maryland 10e. Stete 10b. County 10c. City, Town or Location r than "naturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Directo MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 2706 E. BIDDLE STREET 21213 U.S.A. Funeral 12. Wes Decedant Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) filed within 72 hours after 1 ☐ Yas 2 ☑ No If Yas, Give 1 ☐ Navar Merried 2 ☑ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Yeer or Detas: **NEGRO** X Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglena. Elamentery/Secondary (0-12) Collega (1-4or 5+) 8TH N/A CRANE OPERATOR BETHLEHEM STEEL CO. 17. Fethar's Name (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked oth any injury or other treumstic event sonce. 18. Mothar's Nama (First, Middle, Meidan Sumeme) Be CHARLIE MADISON 2 MARY WALKER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) DAISIE MADISON WIFE 2706 E. BIDDLE STREET BALTO, MD. 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal to BALTIMORE CEMETERY Sept. 3, 1998 BALTIMORE, MD. 21. Signature of Funeral Service Lice 22. Nama and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Pert1. Enter the disease, or complications that course the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heer feilure. List only one ceuse on each inc. Approximate Interval Between Onset end Deeth **Physician** Immediete Ceuse (Finel disaasa or condition resulting in deeth) /Medical BACTEREMIA Examiner Due to (or as a consequenca of): Examiner END STAGE RENAL DISEASE licate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Lest and burial-trag Due to (or es e consequence of): iclan Box 68760 cai Due to (or as a consequence of): E. 8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? Ph 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown The law requires that dat CONGESTIVE HEART FAILURE þ 2 Completed 24b. Were autopsy findings aveilable prior to 24a. Wes an autopsy completion of cause of deeth? page 2 s certificata has 1 Yas 2 JNo 1 ☐ Yes 2 ☐ No of Vital 25. Wes casa referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Certification: 27. Menner of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aftar Division Attending X Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide ò To the Hospital c within 24 hours al To the Funeral D complately filled Medical Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end manner as stated.

[In Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signeture and alle of contifier 29c. License number 29d. Data signed (Month, Day, Year) AUG. 29, 1998 DUNE 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DR. ZIAD YOUNES JOHNS HOPKINS BAYVIEW BALTO, MD. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 1 1998 SEP Registrar

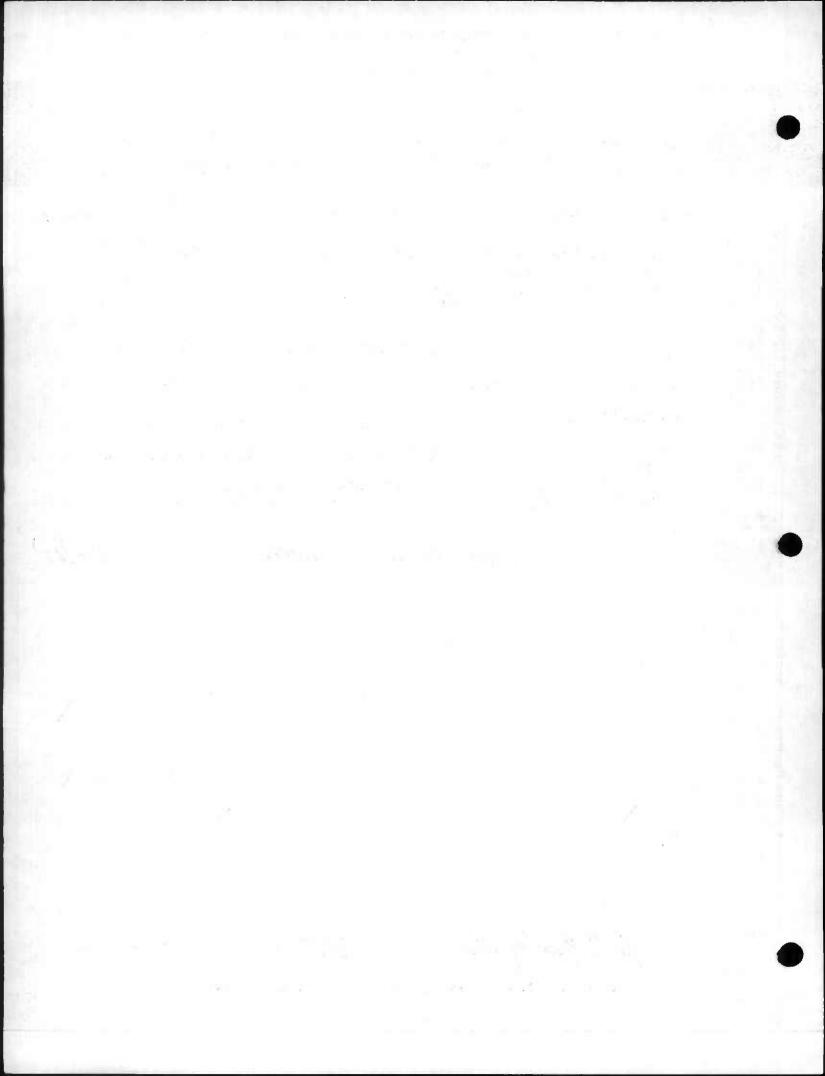


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 1998 KENNETH EARL MELVIN AUGUST 5:30 AM /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** APT. ELLICOTT CITY HOWARD 3351 NORTH CHATHAM ROAD. D 7. Aga (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | 3 - Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | Deys | Menth | 5. Social Security Number Birthplaca (Steta or Foraign
KAIVSAS **Funeral** 1₩M 2□F 499-07-3625 Director Usual Rasidence of Decedant 10e State 10h Count 10c. City, Town or Location 10d. Insida City Limits 28a-f show 7 is marked other than "natural", or flems 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MARYLAND HOWARD ELLICOTT CITY 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3351 NORTH CHATHAM ROAD, APT.D 21042 U.S.A. Funeral filed within 72 hours efter death 12. Was Dacedent Ever In U,S. Armed Forcas? 1 ∑ Yas 2 ☐ No 1939 — If Yas, Giva Yeer or Detas: 1945 13. Was Decedent of Hispanic Origin? (Spacify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) STATIONARY ENGINEER WESTINGHOUSE Peges 1 end 2 should be filed w tment of Health end Mental Hygier tant: If item 27 ie marked other th jury or other traumatic event, un 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be MELVIN PORTER CHARLES RUBY 19a. Informent's Name/Ralationship (Type, Print)
KENNETHH MELVIN JR. / SON 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 6530 REDGATE CIR. CATONSVILLE, MD 20a. Method of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stete cemetary, cramatory or other place, CEDAR HILL CEMETERY 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Depertment of Important: If any Injury or 9/2/98 BROOKLYN PARK, MD 4 ☐ Donation 5 ☐ Other (Spacify) e of Funeral Sarvice Licansee SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 dea 29 Part 1. Entar the disease, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Betwaan Onsat end Death **Physician** /Medical Immediata Causa (Final diseasa or condition rasulting in death) **Examiner** Examiner The law requires thet the deeth certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or injury that initieted evants rasulting in daath) Last Dua to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medicai Due to (or as a consequence of) signed by the ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings eveilabla prior to complation of causa of daath? page 2 should 24e. Was an autopsy performed? peen 1 Yas 2 No 1 ☐ Yas 2 No this certificete Division of Vital or Attending Physician: director, 25. Was casa referred to medical 26. Placa of Death (Chack only one) axaminar? Hospital: 1 ☐ Inpetiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Certification: To funeral 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? After Natural 5 Panding efter death. 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 ☐ Could not be detarmined 3 Suicida 28f. Location (Streat and Numbar or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) in by 4 Homloida 24 hours e Hospital Certifying Phyelcian: To the best of my knowledga, daath occurred et the time, dete and placa, and dua to tha causa(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, daath occurred at tha tima, date and place, end dua to the cause(s) and manner stated. 29a. Certifian Medical completely (Check only one) To the To the To the 29b. Signature and title of pertifie 29c. Licanse numbar 29d. Data signed (Month, Dey, Year) AUGUST 29, 1998 30. Neme and eddrass of person who completed causa of death (Item 23e) (Type, Print) 900 CATON AVE., BALTIMORE, MARYLAND DR. PAUL GORMLEY 32. Registrar's Signature State oaks

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Desedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:00 PM 4a Facility Name (If that institution, give street and number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba timore Avence 8. Date of Birth (Month, Dey, Yeer) 03-18-1932 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1XIM 2□ F 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Maryland Yrs. 66 Director 218-26-8466 Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits rithan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21224 3221 Esther Place Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Americen Indian, 11. Marital Status Black, White, etc. Armed Forces.

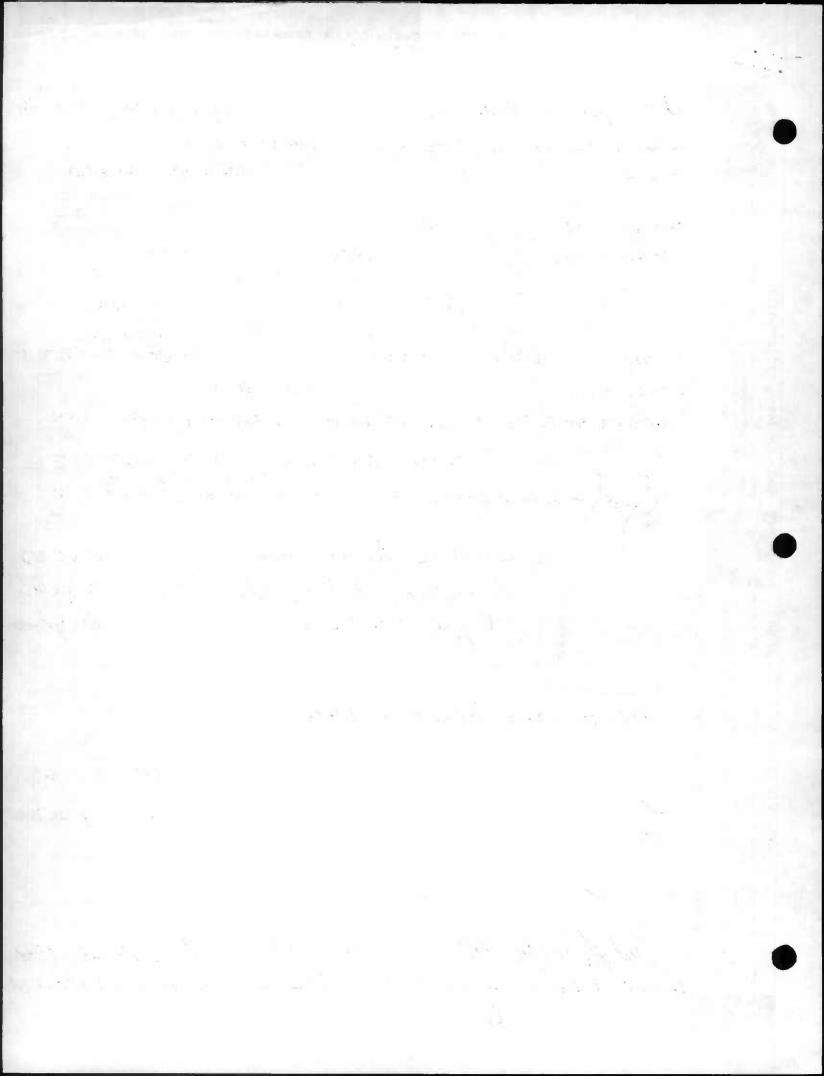
1X:Yes 2 No rean

Year or Dates: Conflict 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Highway Administration 12 Years Inspector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic event ance. Be DeVoy Esther John F. Norris 19b. Melting Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Baltimore, Maryland Virginia M. Norris (Peronal Rep.) 3221 Esther Place altimore, 20b. Place of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-1-98 Timonium, Maryland Dulaney Valley Mem. Gar. 22. Name and Address of Facility Leonard J. Ruck, Inc. of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 J. Wayne Osterling the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and tailure. List only one ceuse on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician end the buriel-trensit law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): ettending p Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by the 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate hes l irector, page 2 s 1 Yes 2 100 1 Yes 2 No 25. Was cese referred to medical examiner?
1 or 2 No director Be 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) group hane 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? or Attending F efter death Khor 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steled.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, end due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer completely fil edicai 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) VAMC 10 NGreeneSt Ballo M/21701 Balto MO LOCE 31. Date filed (Month, Dey, Year) SEP 1 32. Registrar's Signature

DHMH 16 Ray 6/95

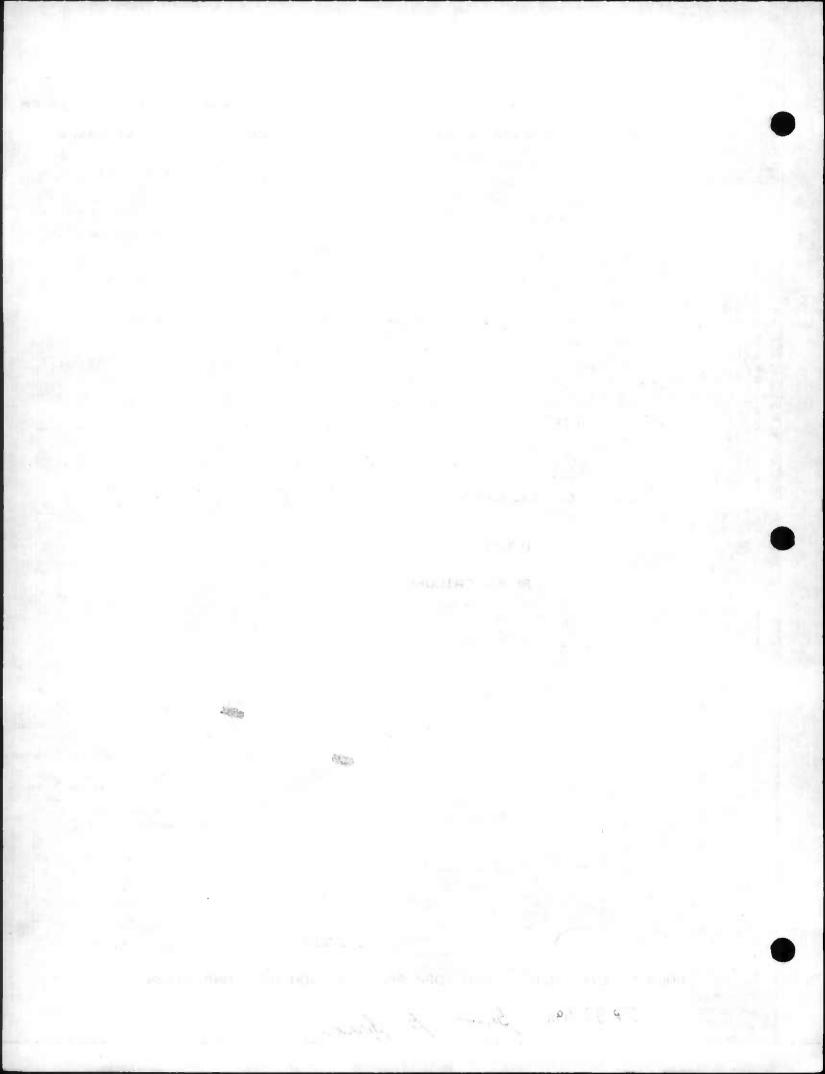
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d				State of M	aryland		artment of F	lealth and N Death		giene <sub>Reg. No.</sub> 98	26651
1	Physician	-	1. Decedant's Nama (First, Middla, La						2. Data of De Month	Day	3. Tima of Death
	/Medica		William E.	0echsler					AUGUST	29, 1	998 12:15 PM
	Examine		la Facility Nama (If not institution, give Saint Joseph		Cent	er		4b. City, Town, or L TOWS 0			altimore
	Funeral Director		220-10-4278	ax 7. Ag	a (In yrs. la 71	st birthday) Yrs.	If Under 1 Yaar Monfhs Days	If Under 24 Hrs. Hours Min.	8. Dafa of Bir (Month, Da Sept.	th ly. Year) 20,1926	9. Birthplaca (Stata or Foreign Country) Maryland
	and	- 1-	Usual Rasidanca of Decedant 10a. Stata 10b. County		10c. City,	Town or Lo	cation	_			10d. Inside City Limits
	ith the Marylar or 28a-f ahow a notified at	2	Maryland Baltimo	re			Baltimor	0			1 ☐ Yas 2X No
	or 28=fa		10e. Street and Number				10f. Zip Code			10g. Citizen of W	That Country?
	23a 23a	3	8507 Daytona Ro	ad			2123	7		u.s	S.A.
020	filed within 72 hours efter death with the Maryland Hygiene. Hygiene than "natural", or hema 23a or 28a-f show ent, tra Medical Examinar must be notified at a Completed by Energial Director		11. Marital Sfatus  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 ∑ Yas 2 ☐ I If Yas, Giva Yaar or Datas:	No		Was Decedent of H If Yas, specify Cubi 1 ☐ Yas 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puarto Specify:	pecify Yas or No Rican, atc.)		a - Amarican Indian, k, Whita, atc. : White
2-0	72 hor	3	15. Decedent's Ed (Specify only highast gra	lucation		16a. Deced	dent's Usual Occup	etion	kina	16b. Kind of Bu	sinass/Industry
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours eft Department of Health and Mentel hygiene. mportant: if item 27 is marked other than "natural", or my injury or other traumatic event, the Medical Example.	The state of the s	Elamantary/Secondary (0-12) 12th Grade	Collega (1-4or s	5+)		tenance E	during most of world) NGiNEEL	ung .	Communi	ity College
Maryland	2 should be flied with and Mentel Hygiene. Is marked other than sumatic event, trees To Re Comm	3	17. Fathar's Nama (First, Middla, Last, Elmer Oechsler					18. Mother's Nam	na (First, Middla Smith		a)
ary	shou and M	-	19a. Informant's Name/Ralationship (	Type, Print)		19b. Mailir	ng Address (Street	and Number or Ru	ral Routa Numb	er, City or Town,	Stata, Zip Code)
	1 end 2 Health a em 27 la		Dorothy B. Oechsl	er (wife	-			Road, Ba	utimore		
Baltimore,	permit. Pages 1 end Department of Health Important: If item 27 any Injury or other to page.	1	20a. Mathod of Disposition  1 ☐ Burial 2 ☐ Cramation 3 ☐	Ramoval from Stata	Cer	matary, crer	sition (Nama of matory or other plac		Data		City or Town, Stata
Itim	tt. Partmen rtant:		4 □ Donation 5 □ Othar (Specif	/)	Sac				9/1/98	Baltimo	ore, Maryland
Ba	pemil. Pages Department of P Important: If ite any Injury or of		21. Signatura of Funaral Sarvice Licer  Buch  G	will	em	S	Nama and Addra Schimunek 1705 Bela	Funeral ir Rd., B	Home, I Baltimor	nc. e. MD 2	21236
	Physician /Medical		23a. Part1. Entar tha disaasa, or com shock, or haart failura. List only Immediata Causa (Final	plications that caused on a causa on each li	i tha daath. na.	Do not ent	ar tha moda of dyir	ng, such as cardiac	or raspiratory a	rrest,	Approximata Intarval Between Onsef and Death
	Examiner d		disaasa or condition rasulting in daath)	a. RENAL		as a consec	quanca of):				
	ate be executed hysicien and the bunal-transit		Sequentially list conditions, if any, laading to immadiata	b		as a conseq	quence of):				
x 68760,	physicle s the bur		Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last	c	Dua to (or a	as a conseq	uanca of):				
Box	attending for use a										
0	the school		Part II. Other significant conditions of	ontributing to death b	ut not rasult	ting in tha u	ndarlying causa giv	ren in Part I.			atribute to the cause of death?
٩	es that se igned be determined by Pt								10	Tes 2□ No	3 Probably Munknown
Records,	heen s									an autopsy omed?	24b. Wara autopsy findings available prior to completion of cause of death?
Re	The lew ate has pege 2								10	Yas 2500	1 ☐ Yas 2 No
Vitai			25. Was casa rafarred to medical axaminar?					26. Place of Dea	th (Check only	ona)	
of V	hys his		1 Yas 2 No	Hospital: Inpatia		R/Outpatier		4 LI Nursing H		danca 6 □Otha	
	After funer		27. Mannar of Death  1 Natural 5 ☐ Panding 2 ☐ Accident invastigation	28a. Data of Inju (Month, Da	y Year) 2	28b. Tima of Injury	Wor	ryat rk? Yes 2 □ No	28d. Describe	how injury occurr	ed
Division	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Affert completely filled in by the funer. Medical Certification:		2 Accidant invastigation 3 Suicida 6 Could not be datarmined		ury - At hom c. (Specify)	na, farm, str	reet, factory, office	2010	28f. Location ( City or To		er or Rural Routa Number,
	To the Hospital within 24 hours a To the Funeral D completaly filled To Medical Ce		29a. Cartifiar 1X Certifying Ph (Check only 2 Medical Exam	ysicien: To the best of the basis of and manner sta	axaminatio	iedga, daath on and/or in	n occurred at tha tir vastigation, in my o	ma, data and place pinion, death occur	, and dua to tha rred at tha tima,	cause(s) and mai data and place, a	nnar as stated. and dua to tha cause(s)
	Merithin		29b. Signatura and fifla	1			29c. Licens			29d. Data signed	i (Month, Day, Year)
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	10x		80. Nama and addrass of person who BOON P. LIM, M	completed cause of d				VSON, MAR	RYLAND	21204	
	State Registrar		SEP 0 1 1998	32. Regisfr			land				

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, I	ast)	Ce	rtificate of	Death	2. Date of Dea	Reg. No. 🦪 🕻	3.1	ime of Death
Physician /Medical	LOUISE LILLIA	N POEHLER				AUGUS	Day ST 29, 1	Year 1998 9:	30 AM
Examiner	4a Facility Name (If not institution, g Saint Joseph	·	Center		4b. City, Town, or Lo			of Death Baltimo	ore
Funeral Director	215-05-5671	Sex 1 M 2X F 7. Age	(In yrs. last birthday, 85 Yrs.	If Under 1 Year   Months   Days		8. Date of Sin (Month, Da Jan 1,	th y, Year) 1913	9. Birthplace ( Country) Maryla	State or Foreign
dand wan	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town or L	ocation				10d. In	side City Limits
Mary Med ah	Maryland Baltim	ore County	Park	ville				- 11	☐ Yes 2 No
after death with the Ma in terms 23e or 28e-1e where man be notified.	10e. Street and Number 2109 Townhill Ro	oad, Apt C		10f. Zip Code	21234		10g. Citizen of \USA	What Country?	777
by	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	ver in U,S. 13.	Was Decedent of I If Yes, specify Cub 1 Yes 2 No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ck, White, etc. White	lian,
ed within 72 hours at yglana. The matural, or the matural, or the matural or the	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 8th	Education rade completed) College (1-4or 5+	(Give		pation during most of work of)	ing	16b. Kind of B	usiness/Industry	
be filed dother avent, n		at)	020		18. Mother's Name	e (First, Middle,			
2 should be filed within a and Mental Hyglana. Is marked other than raumatic avent, the Martin and Mental To Be Comp.	Jacob		Hart		Eva		Du	uckett	
ire, Marylano ZIZ s 1 and 2 should be flied within l Health and Mental Hyglena. Itam 27 is marked other than other traumatic avent, tha Maryland Bacompi	19a. Informant's Name/Reletionship Patricia Eberwe:				Road, Be				J
Page nant o	20a. Method of Disposition  1 \ Burial 2 \ Cremation 3  4 \ Donation 5 \ Other (Spec			osition (Name of omatory or other place)  Cemeter	y q	Date /2/98		City or Town, S	
permit. Pag Department Important: It any injury o	21. Signature of Funeral Service Lic Robert C. Al	tenburg f	AJ		ess of Facility Funeral Hord Road, I			vland 2	21214
Examiner and a burial-transit	Cause (Disease or injury that initiated events	sEPSIS c. RENAL F	tue to (or as a conse FAILURE ue to (or as a conse	quence of):					
at the death or price thy the attending phy elected for use as the Physician/Medi		l d	00 10 (01 83 8 00130	Qualities of j.					
the dear	Part II. Other significant conditions	contributing to death but	not resulting in the u	underlying cause gi	ven in Part I.			ntribute to the	1
5 55 A							Yes 2□No	3 Probably	4 X Unknow
law requests been as been as been applete							an autopsy med?	available complete of death	
defan: The certificate h rector, page					26. Place of Deet	1 Check only o		1 □ Yes	2) No
1 1 1 F	1 Yes 2 No	Hospitat: 1 Mapatien 28a. Dete of Injury (Month, Day	28b. Time o	of 28c. Inju	her: 4 Nursing Ho	me 5 ☐ Resid			
is or Attending Physical and Country and Inceptor: After this of in by the tuneral of Certification: To	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 200 Place of trius	y - At home, farm, st (Specify)			28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural Rou	te Number,
pan y tan		hysician: To the best of eminer: On the basis of e and manner state	xaminetion and/or in	h occurred at the ti vestigation, in my	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and ma date and place,	anner as stated. and due to the o	ause(s)
To the H within 24 To the Fa complete	29b. Signeture end title of certifier		6	29c. Licen	se number		29d. Date signe	d (Month, Day,	Year)
10	1 och	war	1	D 44	728		8/2	9/9	8
13	30. Neme and address of person who MITCHELL L. S(			Print) CHARLES	ST., BA	LTIMOR	RE, MARY	LAND a	1204
State Registrar	31. Date filed Grap Day, Yearn Q	8 32 Registrar	ts Signature 4	Sparks					

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Department	Of	Health	and	mental	Hygiene	3
0		( D 4	_			4.7

4b. City, Town, or Location of Deeth

BALTIMORE CITY

4c. County of Death

PLONA	State of Maryland / Department of Health and	d Mental Hygiene 9 9 2	6653
	Certificate of Death	Reg. No.	
1. Decedent's Name (First, Middle, Last) Evelyn	Plona	2. Dete of Deeth Month Day Year AUGUST 30, 1998	3. Time of De 1308PM
al		AUGUST 30, 1990	TOUGHM

/Medical Examiner

4e Facility Name (If not institution, give street end number)

J.H.H. BAYVIEW MEDICAL CENTER E.R.

**Physicia** 

**Funeral** Director

Pages 1 end 2 should be filed within 72 hours efter death with the Marylend nent of Health and Mental Hygiane. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar mant be notified at

altimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital

5 permit. Page Depertment of important: If any injury or Physician /Medical Examiner

other 1

Examiner physician end s the bunel-transit Physician/Medical attanding p is signed by the ai by Completed peed certificate Be 2

law requires that the death certificate be executed To the Mospital or Attending Physician: within 24 hours after death.

To the Fundral Director: After this certific completely the funeral director,

5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Feb. 3 Birthplece (Stete or Foreign Country) Deys 1□M 2√2 F Months Hours 217-16-1647 74 Yrs Maryland Feb. Usual Residence of Decedent 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits Yes 2 No Directo Maryland Baltimore 10f. Zip Code 21222 10e. Street end Number 10g. Citizen of Whet Country? 6804 Boston Avenue U.S. of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 ☐ Yes ♣☐ No If Yes, Give 1 ☐ Yes 2 🖾 No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Burdynski Estalla Stiletska John 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Cod 21157 19a. Informent's Name/Relationship (Type, Print) 1923 Fridinger Mill Rd. Westminster, Md. Daniel S. Plona ( Son ) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, Stete Date Sept. Stanislaus 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Fecility
W. Dabrowski-Chojnacki F.H.'s P.A. 21. Signeture of Funerel Service Ling 1005 Dundalk Ave. Balto., Md. 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on anoth line. Approximate tntervat Between Onset and Death Immediate Cause (Final . DUTUACE ROBING HOMONPURGE diseese or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy INSPECTION 1 ☐ Yes 25 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 1 Inpatient 2M ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred al Certification: 5 Pending investigation Injury 1 X Natural 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number O.C.M.E. AUGUST 30, 1998

State Registrar

Margarita Korell M.D. 31. Date filed (Month, Dey, Yeer) 1 1998 SEP

32. Registrar's Signature.

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Special Control of tradica wi dudor CONTRACTOR DESCRIPTION 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Russell Petre August 1998 7:25 P.M. 25 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street end number) 4c. County of Deeth **Examiner** Rosedale 8213 Pulaski Hwy., Room #8 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 18,1947 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 XM 2 F Yrs. 212 48 3768 51 Maryland Director Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Middle River Maryland Baltimore Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 2116 Southorn Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status hours after 1 X Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0020 Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiens. Elementery/Secondery (0-12) College (1-4or 5+) Electrician Construction 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 88 Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked or nd Mental marked o Colleen Eaton George Baker 2 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 2116 Southorn Rd. Baltimore, Md. 21220 Cecelia Petre (Personal Rep.) altimore, 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Department of Important: If 8/29/1998 Baltimore, Md. Greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) of Tuneral Service Licens 22. Name end Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 orun e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Coronary disease or condition resulting in deeth) Examiner Dysko (or es e consequence of) Examiner Leroscherotic Lesare the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last the burial-tran Due to (or es e consequence of) pue physicien Physician/Medical Due to (or es a consequenca of) 8 USB 23b. Did tobacco use contribute to the cause of death? ed by the detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. o signed by t 1 Yes 2 No 3 Probably ★ Unknown ivision of Vital Records. þ 24e. Wes en eutopsy 24b. Were eutopsy findings eveilable prior to Completed peen completion of cause of deeth? has 1 Yes 2 No 1 Yes 2□ No certificate Attanding Physician: funeral director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Motel 1 XYes 2 No Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation Injury 1 Naturel 1 Yes 2 No 2 Accident stor 3 Suicide 6 Could not be determined Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide ò 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as stated.

2 Madicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) O.C.M.E. August 26, 1998 Chute, mo ennis J 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrer's Signature State 1 1998 SEP Registrar DHMH 16 Rev 6/95

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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day Year **Physician** STELLA POZEK 28 1998 AUG. 4:10pm /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 307 WOODBOURNE AVE. N/A BALTIMORE If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Dey, Yeer) If Undar 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Age (In yrs. last birthdey) **Funeral** Days 1□ M 212 F Months Yrs. 167-03-7939 87 09-07-1910 **Director** POLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show 10a. State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? me 23a or death with 307 WOODBOURNE AVE. 21212 USA Funeral r than "natural", or items the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yas 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 Widowed 4 □ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 8YRS HOUSEWIFE HOMEMAKER 7 is marked other traumetic event, 18. Mother's Name (First, Middle, Maidan Surnema) 17. Father's Name (First, Middle, Last) . Peges 1 and 2 should be fill tment of Health end Mantal Hi tant: If Itam 27 is marked oth jury or other traumatic even Be JOSEPH KOLODZIEJSKI LAURA ZURAWSKI 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 307 WOODBOURNE AVE. BALTO., MD. 21212. MAXINE GROSSHANS (DAUGHTER) 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State permit. Pege Department of important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) PITTSBURG, PA. AUGUSTINE CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Arrest /Medical Immediate Cause (Final Cardio pulmongry disease or condition resulting in death) Examine Examiner enmonia physician and s the burial-transit requiras that the death certificeta be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last A) zheimers 15erse of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): ettending pl Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 25 No 3 Probably 4 Unknown by 24b. Wera autopsy findings availabla prior to completion of causa of death? Completed 24a. Was an autopsy s certificate has b 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Mesidence 6 □Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Certification: vision 1 Netural Attending 5 Pending 1 ☐ Yes 2 ☐ No 24 hours aftar deeth. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Sulcida Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a. Certifier To the To the Comple 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian Whomely MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Yar) 1 1998 SEP

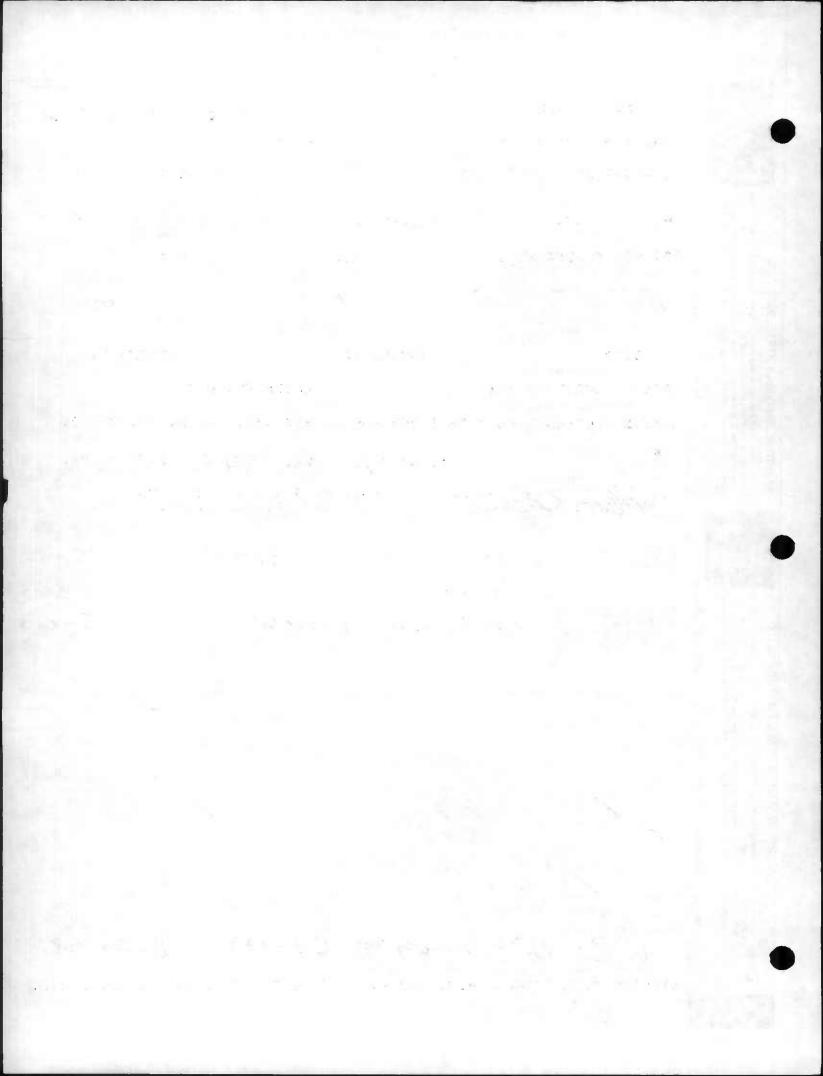
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32. Regigirar's Signature ener

WILLIAM D. McCONNELL M.D. 500 W. UNIVERSITY PKWY. BALTO., MD. 21210.

**DHMH 16 Rev 6/95** 

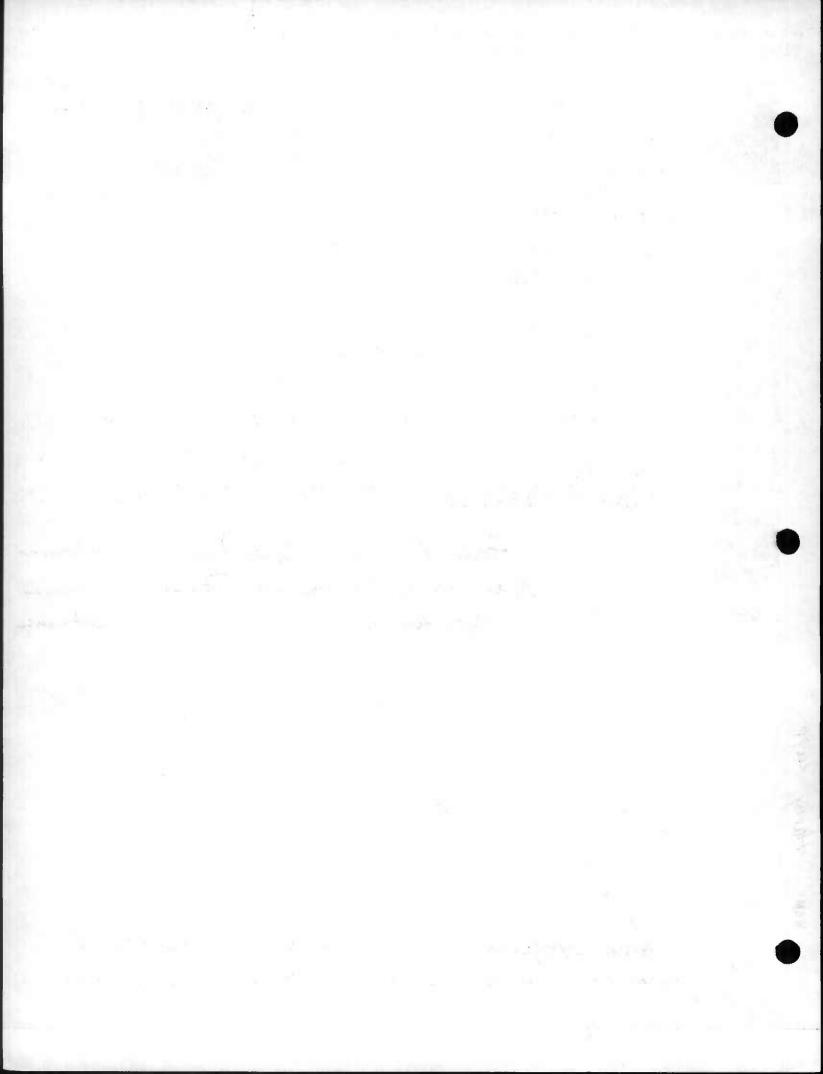
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3 Time of Deeth **Physician** Harry Raymond Rupp AUGUST 1998 1907 30 /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore N/A 8. Dete of Birth (Month, Dey, Year) Feb 21, 1908 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplece (Stete or Foreign Country) **Funeral** 11X1M 2□ F Months Days Hours 213-09-3072 90 Yrs. Pennsylvania Director Usuel Residence of Decedent the Merylend 10a. Stete permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show eny Injury or other treumatic event, the Modical Examines must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Arbutus 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21227 1005 Plover Drive United States Funeral 12. Wes Decedent Ever in U.S. Amed Forcas? ↑⊕Yes 2□No 2/32 If Yes, Giva Year or Dates: 4/33 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amaricen Indien, Black, Whita, atc. 1 Never Married 2 Married 21215-0020 Specify: White 1 Yes 2 XNo Specify: ò 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Iron Worker Steel Maryland 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surneme) Be John L. Rupp Cathryn Ramsey 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) Leona G. Wilhelm, daughter 1005 Plover Drive Arbutus, Maryland 21227 Baltimore, 20b. Plece of Disposition (Neme of cometery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Othar (Spacify) New Cathedral Cemetery9/2/98Baltimore, Maryland 21. Signeture of Funeral Se 22. Name end Address of Fecility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part1. Entar tha diseese, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or heer failure. List only one ceuse on each line. Approximete Intervel Batween Onset end Deeth Physician Immediete Causa (Final disease or condition resulting in deeth) /Medical Myo cardia Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to Immadiata ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in death) Last Due to (or es a consequence of): P.O. Box 68760. er Henson The law requires that the death certificate be bee to (or as a consequence of) - PSD Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were eutopsy findings availabla prior to completion of ceuse of deeth? pege 2 should Completed 24e. Wes an eutopsy performed? hes 1 ☐ Yas 2 ☑ No 1 Yes 2 No certificate or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify) Certification: To 2 ER/Outpatient 3 DOA Division of this 28a. Date of Injury (Month, Dey Year) 27. Menmer of Death 28c. Injury et Work? 28d. Describe how injury occurred After t 5 Pending invastigation 1 ☐ Yas 2 ☐ No deeth. the f 2 Accident efter deeth 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide within 24 hours of To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

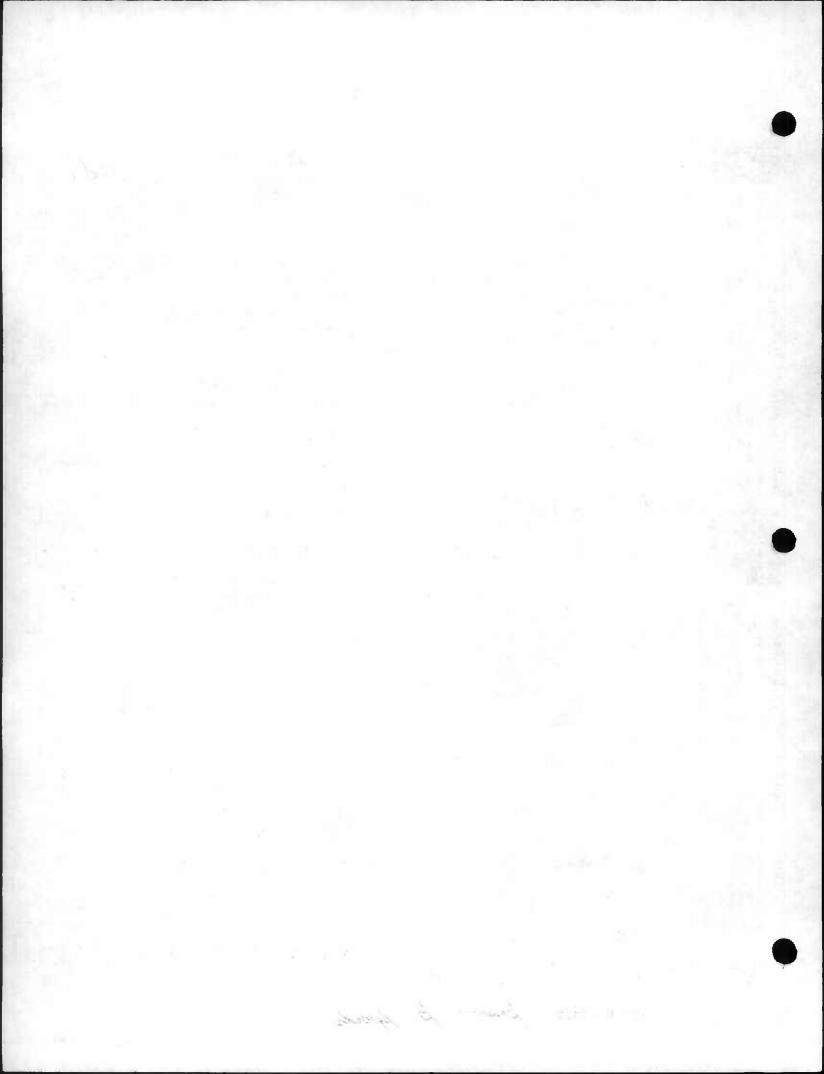
2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end mennar stated. (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Dete signed (Month, Dey, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 21229 EVIN SCRUGAS MI) 900 caton Nunue 31. Dete filed (Month, Day, Year) 82. Registrer's Signeture State SEP 0 1 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Physician Stephen Raczkowski August 1998 30, 12:35 A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5318 Wright Avenue Baltimore If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days **Yrs** 93 Director 207-03-9657 August 23,1905 10 Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow in than "natural", or items 23s or 28s-f above the Medical Examiner must be notified at 1 Yas 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death v
Department of Health and Mantal Hygiene.
Important: if item 27 is marked other than 'natural', or itema 23a
angle. 5318 Wright Avenue 21205 Funeral S. A. Was Decedent Evar in U,S. Armed Forcas? 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 X No If Yas, Giva Year or Datas: 1 Never Merried 2 Married 21215-0020 1 ☐ Yas 2 No Specify: Specify: White Be Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Grade Electrician Oil Heat Service Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) John Raczkowski Mary Skrocka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Raczkowski (Daughter) 5318 Wright Avenue, Baltimore, Maryland 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 19/1/98 Baltimore. Maryland Green Mount Crematory 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility
Schimunek Funeral Home Inc. market 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximeta Interval Between Onset and Death Physician Immediata Causa (Final diseese or condition resulting in death) /Medical Preumonia Aspiration 2 months Examiner Dua to (or es a consequence of) Examiner ears Congrestive The law requires that the death cartificete be asscuted Sequentially list conditions, if any, leading to immadiata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) physician and Box 68760, Physician/Medicai Dua to (or as e consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No ð 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed this certificate has 1 Yas 2 NO 1 ☐ Yas > No or Attending Physician: Medicai Certification: To Be 25. Was casa refarred to medical 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 1 Yas 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death
1 Natural
2 Accident 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending invastigation efter death.

Director: Aft
d in by the fur 1 Yas 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Plece of Injury - At homa, farm, street, factory, office building, alc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours of To the Funerel D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatura and title of certifie 29c Licensa number 29d. Date signed (Month, Day, Year) completed causa of death (Item 23a) (Type, Print) Jong Johns De 6 31. Date filed (Month 1998 <sup>1</sup>Registrar's Signatura State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) Month Yeer **Physician** Beverly Ann Rion 29, 5:25 PM August 1998 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1706 Harbinger Trail Edgewood Harford If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1□M 2ØF Days Months Hours 53 Yrs. 218-44-2624 Director Nov. 2, 1944 Maryland Usual Rasidence of Decedeni permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important if item 27 is marked other than "natural" any injury or other traumatic axes. 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 1 ☐ Yes 2 X No Maruland Harford Directo Edgewood 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 1706 Harbinger Trail 21040 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) Grocery Store 12th grade Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Harry Haas Mildred Schramm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Floyd Rion. Jr. (husband) 1706 Harbinger Trail, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery 9/2/98 Baltimore, Maryland 4 □ Donation 5 □ Othar (Specify) 22 Name and Address of Facility Schumuner Funeral Home, Inc. 21. Signature of Funeral Sergice Licenses 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete tntarval Between Onset and Daath **Physician** /Medical Immediate Cause (Final breast cancer 5 years metastati diseasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or Injury that initiated avents resulting in death) Last Due to (or es e consaguence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): ettending p Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part t. 23b. Did tobecco use contribute to the cause of deeth? ed by the detached signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of ceuse of daeth? should 24a. Was an autopsy Completed irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was casa rafarrad to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Daath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After t 1 Natural or Attanding 5 Panding 1 ☐ Yes 2 ☐ No investigation after death. 2 Accidant Director: / 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 8/31/98 D28239 ( Danks mo 30. Name and address of parson who complated cause of death (Item 23a) (Type, Print) Oncoby, Center, 600 N. Wolfe St Baltimon mp 21287 John Hopkins

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) SEP 0 1 1998

32 Registrar's Signature

The street Same

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Year Month **Physician** Louise H. Roth 5:22 AM Aug. 29 1998 /Medical 4a Facility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health Care Nursing Home Forest Hill Harford If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days 1□ M 2□ F Yrs. Director 219-01-5875 June 29 1917 Maryland Usual Rasidance of Decedant 10b. County 10a. Stata 10c. City, Town or Location 10d. Insida City Limits Show "netural", or items 23s or 28s-f show 1 Yas 2 No Director MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 109 Forest Valley Dr. 21050 USA permit. Pages 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or hema 23 any Injury or other traumatic avent, the Medical Examinal must once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indien, Black, Whita, atc. 1 ☐ Yas 2)(No If Yas, Giva Year or Dates: 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 □XVidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 n/a Aircraft Builder Martin Marietta 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Frederick G. Hamel Mary M. Hamel P 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Kenneth A. Hamel/Brother 3238 Hamel Lane, Stewartstown, PA 17363 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a, Mathod of Disposition 20c. Location - City or Town, Slate Data 1 XBuriel 2 □ Cramation 3 □ Removel from State Oak Lawn Cemetery 9/1/98 4 ☐ Donetion 5 ☐ Othar (Specify) Dundalk, MD 22. Nama and Addrass of Facility ice Liophse Lemmon Funeral Home Michael Flagle 10 W. Padonia Rd., Timonium, MD 21093 23a. PertT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediala Causa (Final ears disaasa or condition rasulting in death) Examiner Due to (or as a consequence of). Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as e consequence of): Box 6876 Physician/Medical Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? Ē 1 Yes 2 No 3 Probably 4 Unknown Records. à Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings aveilable prior to completion of cause of death? 1 ☐ Yas 2 ☐ No certificate Division of Vital Be 25. Was case refarred to medical examinar? 26. Place of Death (Check only ona) examinar? Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 報 in 24 hours after death.

S Furerial Director: After re-27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the to To the to the to the to 29b. Signeture end little of-certifie 29c. License number 29d, Dala signed (Month, Day, Year) M.X Jun. 30. Nama and addrass of person who completed ceuse of death (Item 23a) (Type, Print) 800 Harford Rd. tallston, UN, M.D

DHMH 16 Rev 6/95

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Registrar

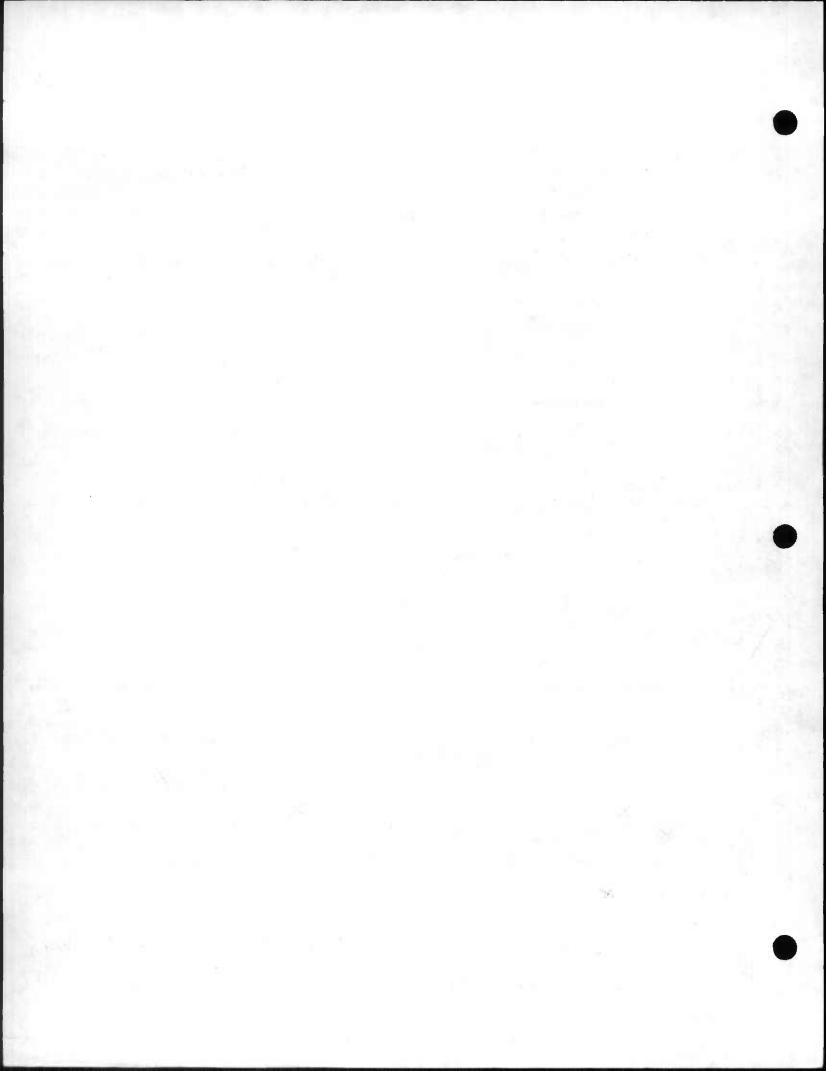
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32. Registraris Signature



Physician	1. Decedant's Nama (First, Middla, L	ast)		Certificate of	Death	2. Data of De	Reg. No.	3. Tima of Deat
/Medical	Dohald	Rid	2/44			Month	Day	Year 11:28
Examiner	4a Facility Nama (If not institution, g		/		4b. City, Town, or L.			
	Northwest Hospi				Randalls	town	Balt	imore
Funeral Director	5. Social Security Number 6. 219–40–2737  Usuat Rasidence of Decedant	Sax 7. Aga 7. Aga 5.5	(In yrs. last birt	hday) If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bi (Month, D Feb.	18,1943	9. Birthplaca (Stata or Fore Country) Maryland
8 11	10a. Stata 10b. County		10c. City, Town	or Location				10d. Inside City Lim
to for	Maryland Balti	more	Randa	11stown				1 □ Yas 2 🕞
r 28a	10e. Street and Number			10f. Zip Code			10g. Citizen of V	/hat Country?
al D	3247 Green Knol	1 Road		2124	4		United S	States
at, or items 23s or 28s-f show Example must be notified at by Funeral Director	11. Marital Status  1 Nevar Married 2 Married  3 Widowed 4 Divorced	12. Was Dacedent Ev Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas:		13. Was Decedent of H If Yas, specify Cub 1 ☐ Yas 2 No	dispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yas or No Rican, atc.)	5 14. Race Blace Specify	e - Amarican Indian, k, Whita, atc. : : White
"natural".	15. Decedant's	Education	16a.	Decedent's Usual Occup (Giva kind of work dona life. DO NOT use retire	pation	ina	16b. Kind of Bu	
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2 0 2	19a. Informant's Name/Ratationship			Mailing Addrass (Street				
	Kristine Jorda	n		11 Michele		Data		City or Town, Stata
E # 0	1 ☐ Burial 2 🖾 Cramation 3			Disposition (Nama of y, crematory or other pla				
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importan any injur	23a. Parti. Inter the disease, or co- shock, or heart failure. List only	mplications that caused the	ha daath. Do n	8728 Liber	Lor ty Road,	Randal.	lstown, l	ral Directors Maryland 2113 Approximata Interval Batween
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ording physiques as the but	Sequentially list conditions, if any, laading to immadiate causa. Entar Undarfying Cause (Disaase or Injury that initiated events resulting in death) Last  Part II. Other significant conditions	d		onsequanca of):	ven in Part I.	23b. Did	tobacco usa con	1
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been signed by the attending physicial should be detached for use as the balanded by the state of the state o	resulting in death) Last	d		onsequanca of):	ven in Part I.	1 Z4a. Wa	Yes 2□ No	24b. Wera autopsy findin available prior to completion of causa
been signed by the attending physicial should be detached for use as the balanded by the state of the state o	resulting in death) Last	dcontributing to death but		onsequanca of): tha undarlying causa gi	26. Place of Deal	24a. Wa	Yes 2□ No s an autopsy ormed?  Yas 2□ No	24b. Wera autopsy findin available prior to completion of causa of death?
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State of Maryland / Department of Health and Mental Hygiene

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# ADOM, MORRIK

26662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** MORRIS RADOM AVGUST 38 10:25A /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MERCY HOSPITAL STELLA MARIS HOSPICE BALTIMORE N/A If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year)

JAN. 14,1922 If Under 1 Yaar 7. Age (In yrs. lest birthday) Birthplaca (State or Foreign Country) **Funeral** XXM 2 F Months Days 094-14-3318 Director 76 RUSSIA Usuel Rasidenca of Decedent 10b. County 10c. City. Town or Location 23a or 28a-f show 10d. Inside City Limits Examiner must be notified at Director XXYas 2□No BROWARD SUNRISE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2800 PINE ISLAND ROAD 33322 U.S.A. Funeral Hems 12. Wes Decadent Evar in U,S. Armed Forces? 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Marriad 3 ☐ Married 5 Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: If Yes, Give Yeer or Detes: Specify by 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) 12 PROPRIETOR HOME IMPROVEMENT Is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be Department of Health and Mental Important: If Item 27 Is marked o **AARON** RADOM 2 CLARA LANSMAN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Steta, Zip Code) RITA RADOM (WIFE) 2800 PINE ISLAND ROAD SUNRISE, FL 20b. Piece of Disposition (Neme of cametery, cremetory or other place) RDENS 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Othar (Specify) STAR OF DAVID MEMORIAL 8/30/98 NORTH LAUDERDALE, FL of Funeral Sepr 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 hat caused the daath. Do not enter tha moda of dying, such es cardiac or raspiratory arrest, on eech line. Approximeta Intervel Batweer Physician /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner The iaw requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceusa (Disease or Injury that initieted events resulting in deeth) Lest buriei-trar Bud Due to (or es e consequence of) Box 68760, physician s the burie Due to (or as a consequence of) P.O. Pert Ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uaa contribute to the cause of death? signed by the 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ Completed 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? paga 2 : 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Vital Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) # OSDic = At Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) S + E// MAR'S 1 Yes 2 No 2 oto this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred of or Attending Parter death. Division 1 Natural 5 Pending 1 Yes 2 No Accident 3 ☐ Suicide invastigation ector: 6 Could not be in by 28e. Plece of Injury - At home, ferm, streat, factory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Fonera 12 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 29e. Certifier Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end manner stated. 29b. Signatura end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) moments. 040480 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Belin 5810 G, U. FERRO, MO FERNANDO Barro 31. Dete filed (Month, Day: Year) 32. Registrer's Signeture State

Sporker

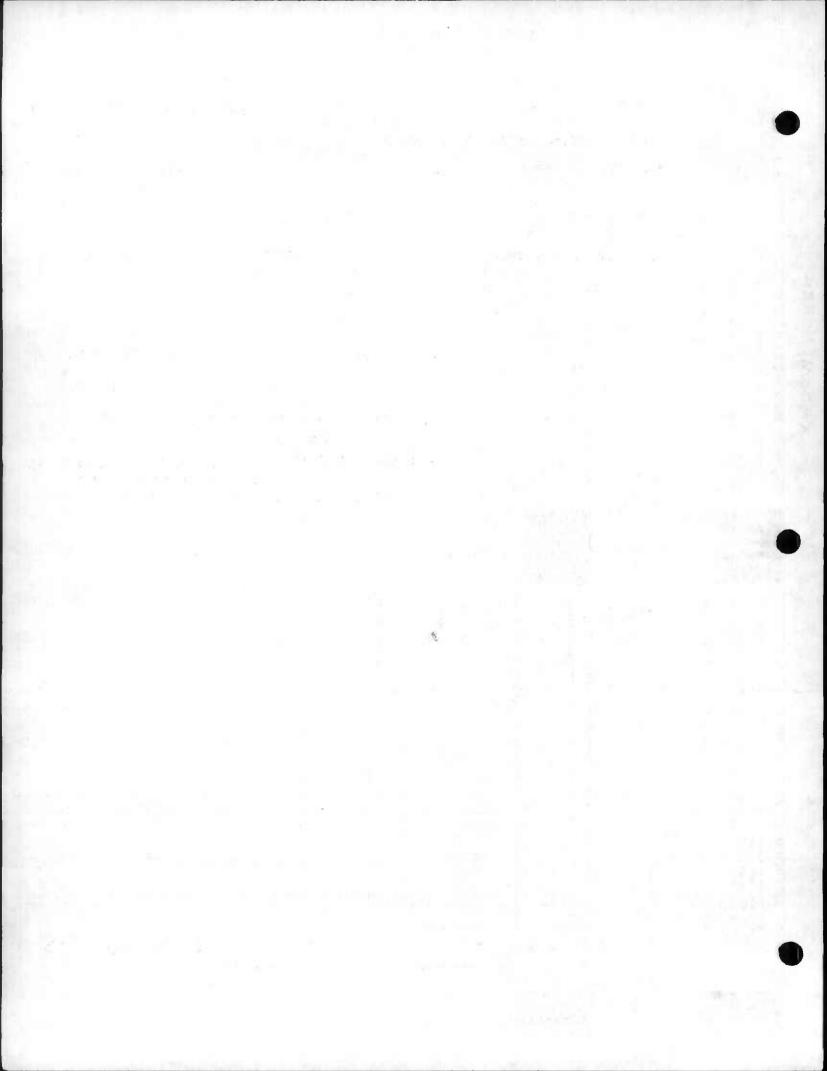
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

DHMH 16 Rev 6/95

Registrar

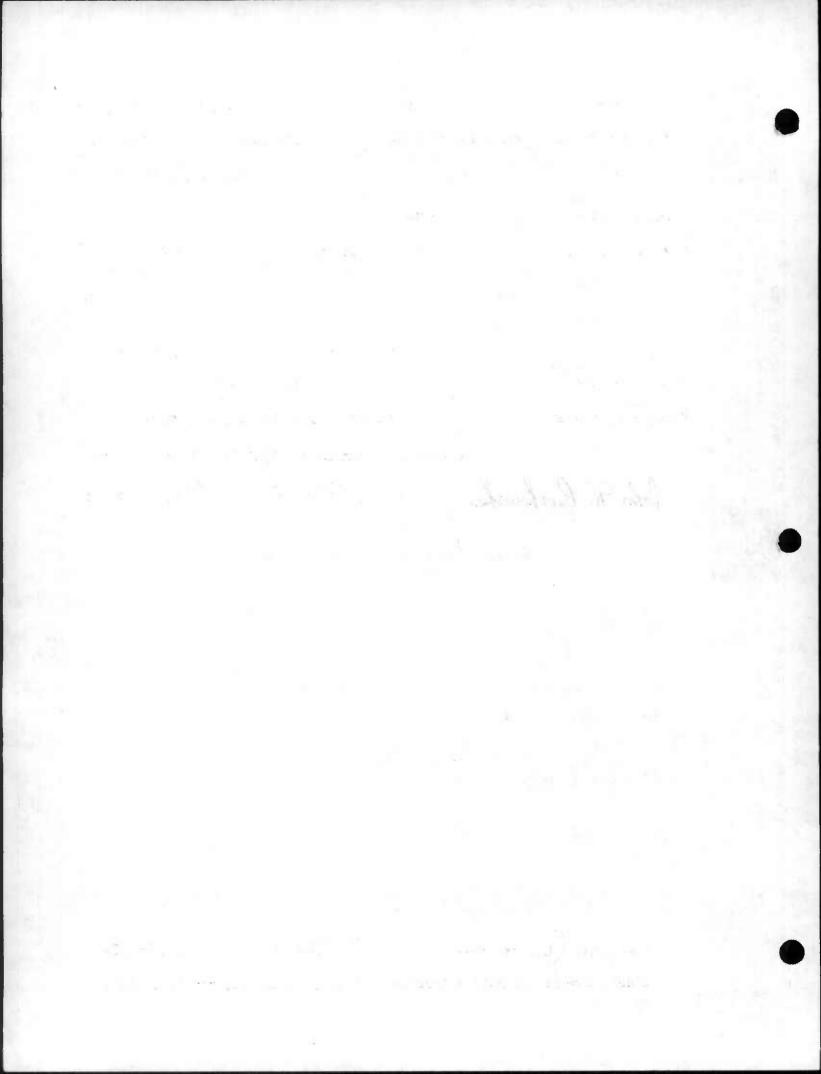
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			State	of Maryla	nd / Depa	artment of rtificate of	Health and Death	d Mental Hy	giene G	18 2	26663		
Physic	an	1. Decedent's Name (First, Middle, Las	t)					2. Date of De Month	eeth Day	Year	3. Time of Death		
/Medi		Sarah			Rap	p		August	28,	1998	10:25 PM		
Examir	ner	4e. Fecility Neme (If not institution, give				,	•	or Location of Deel		nty of Deeth			
Francis		Riverview Nursing 5. Social Security Number 6. So			. last birthdey)		Balti H Under 241			ltimor			
Funeral Director		220 01 3552	□M 2⊠F	81	Yrs.	Months Days		Ain. (Month, D	9y, Year) 1, 191		plece (Stete or Foreign stry)		
and we		Usual Residence of Decedent  10e. State 10b. County		10c. C	ity, Town or Lo	ocation		-					
Maryl Fed	tor	Maryland Baltimore	2		iddle R				10d. Inside C				
r 28a	Director	10e. Street end Number				10f. Zip Code			10g. Cifizen of Whet Country?				
23a c	alD	107 Roundup Rd.				2122	20		USA				
and Mental Hygiens.  marked other than "netural", or items 23s or 28s-f show imatic event, the Medical Examiner must be notified a	by Funeral	11. Marital Stetus  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Fo 1 ☐ Yes If Yes, Gi	12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:				(Specify Yes or No uerto Rican, etc.)		Race - Americ Bleck, White, cify: Wh			
etura Ical E	ted	15. Decedent's Ed	ucafion		16a. Dece	dent's Usuel Occu	petion		16b. Kind o	Business/Inc	dustry		
Mad Nad	Completed	(Specify only highest grad	le com <i>pleted)</i> College (		(Give	kind of work done DO NOT use retire	during most of ed)	working			,		
rther th	Соп	12			Sal	es Clerk			Depart	ment S	store		
ked oth	To Be	17. Fether's Neme (First, Middle, Lest) Samuel Felcher						Name <i>(First, Middle</i> hillips	, Maiden Surr	eme)			
0 00 =	-	19e. Informent's Name/Reletionship (T					t end Number or	Rurel Route Numb			Code)		
item 27 i		Harry Rapp (Husbar	nd)					imore, Mo	1. 2122	0			
nt: If ite		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ i	Removel from			sition (Neme of natory or other ple		Dete /24 /4 000		n - City or To			
rlant		4 Donetion 5 Other (Specify, 21. Signature of Funeral Service Ligens		GIE		t Cremat		/31/1998	Baltim	ore, M	d.		
Important: If it any injury or conce.		Signature distributed Service Ligaria	0	0	Br	Name end Addr uzdzinsk	i Funer	al Home E Avenue Es	A.				
A for use es the buriel-transit	n/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)  Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest	Periph	Due to (	or es e consequences	uence of):	- Gang	zene			Oldewoun		
the ette	sicia	Pert JL. Other significent conditions con	atributing to de	eath but not res	sulting in the ur	deriving cause of	ven in Pert I	23h Did	tobecco use	contribute to	the cause of death?		
ld be detached	by Physician/M	Cormony Actory ?		our por not rec	outing in the u	idenying cause gi	voil iii Foit i.				pably 4 Donknown		
2 shou	Completed	Diosetes							en eutopsy rmed?	COL	ere eutopsy findings pileble prior fo appletion of ceuse deeth?		
pe ate	Con	Poplebler Der	pase					10	Yes 2 □tNo	10	Yes 2□ No		
certificate rector, peg	Be	25. Was cese referred to medical examiner?	loenital:					Deeth (Check only o	one)				
Attér this funeral di	ation: To	27. Menner of Deeth  1  Maturel 5 Pending 2 Accident investigation		Inpatient 2 of Injury th, Dey Year)	28b. Time of Injury	28c. Inju		g Home 5 Resi			/)		
in by	Certification:	3 Suicide 6 Could not be determined	28e. Plece buildi	of Injury - At h ng, etc. <i>(Specil</i>	ome, farm, sfre	eef, factory, office			Location (Street end Number or Rurel Route Number, City or Town, State)				
To the Funeral Completely filled	edical	29a. Certifier 1 CertifyIng Physical Check only one) 2 ■ Medicel Exemi	ner: On the be	best of my kno esis of exemine ner stated.	wledge, deeth tion end/or Inv	occurred et the ti estigation, in my	me, dete end pla opinion, deeth oc	ace, end due to the ccurred et the time,	ceuse(s) end date end plac	menner es st e, end due to	eted. the ceuse(e)		
Toth	-	29b. Signature end title of cartifier	-			29c. Licens	se number		29d. Date sig	ned (Month, I	Dey, Year)		
		Allevel (1	Luca	ans		DI	3667		8 3	30/88	2.		
		30. Name and address of person who co											
100		Michael Schwart	z MD 5	517-A R	itchie	Highway	, Balt:	imore, Ma	ryland	21225			
Stat Registra	e ar	31. Dete filed (Month, Day Year) 8	Se R	egistraris Signe	eturet	porte	į.						

DHMH 16 Rev 6/95



## Plea

Please	Type or P	rint in Black	k Indelih	le ink	Assure	All Copie	s Are Legil	hle	
T louis		Maryland / D		ent of H	lealth and		_		6664
1. Decedant's Nama (First, Middla, Las	ist)					2. Data of D	Death		3. Tima of Death
Elsie H	artzell	Ran				AUG 2	28. 1998	Yaar 1	2:10 AM
4e Fecility Nama (If not institution, give				- 1	4b. City, Town, or				
Howard County	the state of the s		o 1		Colum	nhia		ward	
5. Social Security Number 6. S		. Aga (In yrs. last birti	thday) If Unde	dar 1 Yaar	If Under 24 Hrs	rs. 8. Date of B			a (Stata or Foraign
	1□ M 2 <b>X</b> F		Yrs. Months	ns Days	Hours Min	July (	Day, Year) D2, 1925	Pennsy	lvania
10a. Stata 10b. County		10c. City, Town	n or Location					10d.	Insida City Limits
MD Howa	. rd			Lico	tt City				1 ☐ Yes 2 No
	.Lu				it bily		I an obtain of V		
10e. Street end Number			101. 2	Zip Code			10g. Citizan of W		
9780 01d Annap					1042		1	JSA	
11. Maritel Status	12. Was Dacada Armed Forca	ant Evar in U,S.	13. Wes Dac	adant of H	lispanic Origin? (S an, Maxican, Puar	(Specify Yas or Nanto Rican, atc.)		e - American k, Whita, atc.	
1 Never Marriad 2 Married 3 Widowed 4 Divorced	1 Yas 2 If Yes, Giva	No		2 No	Specify:	No thous, and		Whit	
15. Decedent's Ed (Specify only highast gra	ada complated)		Decedent's Usi (Giva kind of w lifa, DO NOT	vork dona	pation during most of wo	orking	16b. Kind of Bu	isiness/Indus	try
Elementery/Secondary (0-12)  17. Fethar's Name (First, Middle, Last)	Collega (1-40	10/51)			oir Dir	ector	Ch	urch	
23a. Part1. Enter the disace a companion of the control of the con	Acut	20b. Place of comater Metro  Netro  Netro  Dik  Usad tha daath. Do noth line.  Le Respin  Dua to (or as a comate of the comate o	780 Old  f Disposition (Non- ry, crametory or Crema  22. Nama a Crema  299 F not antar tha mo  ratory consaquanca of consequance of ct Inf	Annal Name of protein and protein and Address attions and Address attions and Address attions are also and address and Address attions are also and address attions are also and address attions are also and address attinuous at	polis Rd ca) y, Inc. ass of Fecility n Socie crick R ng, such es cardia	d. Ellic Data 08/29/98 ety of Road Ba	cott City 20c. Location - Balti MD, Inc	, MD 2 City or Town more,	1042 , Stata MD
Part II. Other significent conditions of Cerebral Atro-	phy		tha undarlying	j cause giv	en in Part I.	1 [ 	id tobecco use con	3 Probab  24b. Were availa comp of dee	eutopsy findings abla prior to letion of causa ath?
Depression	1						Yes 2□No	1 🗆 Y	es 2 No
25. Was case referred to medical axaminar?	Hospitat:	, all 50/0		Oth	har:	Death (Chack only		· (Canaiba)	
1 ☐ Yas 2 ☐ No  27. Manner of Death	28a. Date of I		utpatient 3□ £ Tima of	DUA	4 LI Ruising	-	asidance 6 Other		
1 Natural 5 Pending	(Month,		Injury	28c. Injur	rk? ]Yas 2 □ No				

Physician/Medical Examiner attending physician and for use as the burial-mar Islon of Vital Records, P.O. Box 68760 certificate be requires that the death signed by the a id be detached to Completed by The law has cartificate Be Certification: To this pulpu

25. Was case referred to medica axaminar?
1 ☐ Yas 2 ☐ No 27. Manner of Death 5 Pendi 2 Accidant

3 Suicide

(Check only one)

29e. Certifier

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

invastigation 6 Could not be determined 4 Homicide

28e. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Straat and Number or Rurel Route Number, City or Town, Steta) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifi

29c. Licansa number D5036

29d. Date signed (Month, Day, Year) August 29, 1998

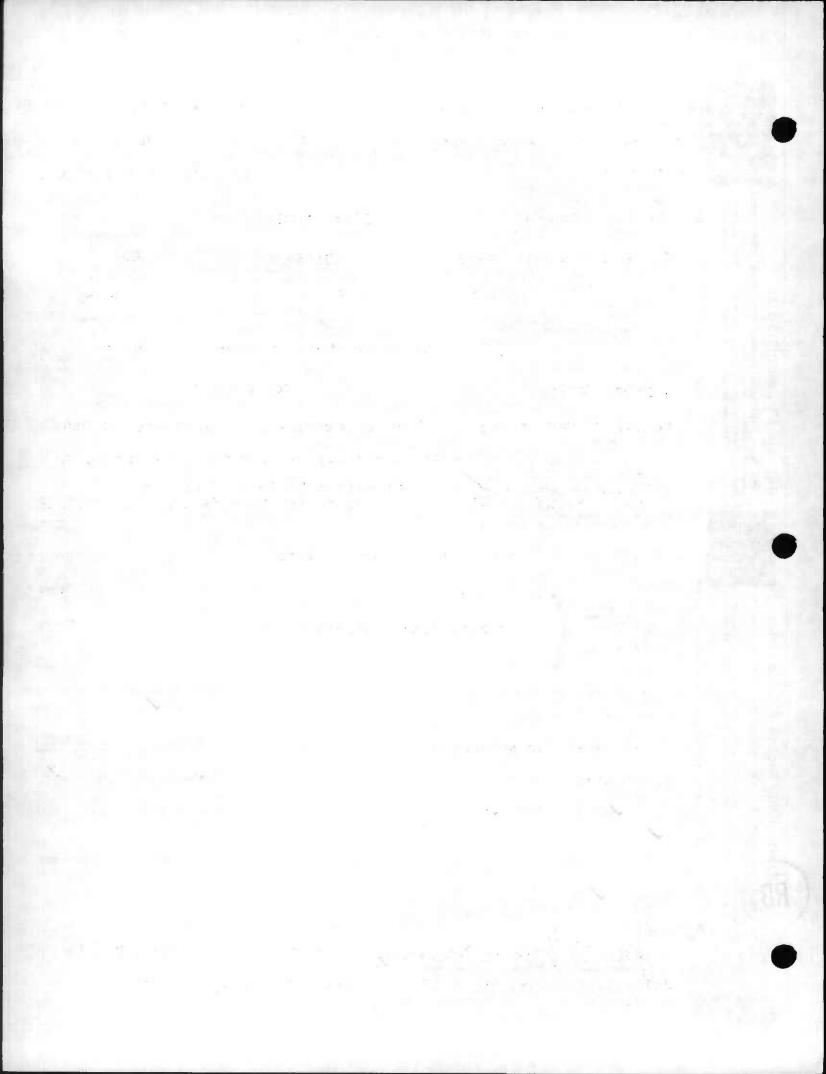
on the completed causa of daath (Itam 23a) (Type, Print)

Bonacum 5755 Cedar Lane Columbia, MD 21044 MD. 31. Data filed (Month, Dey, Year)

State Registrar

Medical

32 Registrar's Signature



Physicia /Medic

Examin

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Deportment of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinating man be notified at an once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The lew requires that the death certificate may within 24 hours effar death.

To the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be datached for use as the puring

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Certificate	of	Death		R	eg. No.	01 2	0000
1. Decedant's Name (First, Middle, Las	t)						2. Data of Deat	h		3. Time of Daath
ETHEL LOUVINA ROW							Month 8	Dey 28 1	Yaar 998	6.40PM
4a. Facility Name (If not institution, give	street and number)				4b. City, To	wn, or Lo	ocation of Deeth		y of Deeth	-
MARINER HEALTHCAN	RE				GLEN	BIIBI	מדד	ANNE	ARUN	DEL
5. Social Security Number 6. S		(In yrs. last bi	irthday) If Under 1		If Undar	24 Hrs.	8. Data of Birth		9. Birth	olaca (State or Foreign
234-34-9236 Usual Rasidanca of Dacedant	□M 2 <b>X</b> 0F 98		Yrs. Months	Days	Hours	Min.	(Month, Day, 8-3-190	_	WEST	VIRGINIA
10a. Stata 10b. County		10c. City, Tow	vn or Location							10d. Inside City Limits
MD ANNE ARU	INDEL	GLEN B								1 ☐ Yas 2 🌠 No
10e. Street end Number			10f. Zip C				1	0g. Citizan of		ntry?
2 NORTH BROADVIEW	12. Was Decedent Ev	er in II S	2106 13. Was Deceda		lionania Ori	lain? (Cn	naih. Van ar Na	U.S.A	e - Americ	non Indian
1 □ Navar Marriad 2 □ Marriad 3 □ ₩ Vidowed 4 □ Divorced	Armad Forces? 1 ☐ Yas 2 ☐ No If Yes, Giva		If Yas, specif	y Cubi	an, Maxicai	i, Puarto	Rican, atc.)		ick, Whita,	etc.
15. Decedent's Ed	Yaar or Datas:	16a	. Decedant's Usual					16b. Kind of E		
(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		(Give kind of work life. DO NOT use	done retired	<i>during</i> mos d)	t of work	ing			
11		HO	USEWARES	DEN				STANLE		E
17. Fether's Nama (First, Middle, Last)					18. Moth	ar's Name	(First, Middle, M	Maiden Sumai	m <i>e)</i>	
DANIEL	LEMON				ELLI	EN VI	RGINIA	WESTFA	LL	
19e. Informant's Name/Raletionship (7		1	o. Mailing Addrass ( 289 AMMEN							
SALLEE FITZSIMMONS 20e. Method of Disposition	/ GRANDDAUG	20b. Piace o	of Disposition (Neme		201		Data	20c. Location	- City or To	own, Stata
1 X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			IAVEN MEMO		,	RK E	3-31-199	8 GLEN	BURN	TE
21. Signature of Funeral Service Licens	588		22. Name end					0 0 0 0 0 0 0 0 0		
> 6 / 1 V			SINGLET	'ON	FUNE	RAL F	IOME P.A			
Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Cause (Disaasa or Injury thet Initiated avants	c		consequence of):							
rasulting in death) Last	d									
Part II. Other aignificant conditions co	ntributing to death but	not rasulting l	n the underlying cau	ısa niv	an in Part i		23b. Did to	bacco usa ce	ontribute to	o the cause of death
					all in Fait			es 2 No	3□ Pro	
Demention Degeneration	we join	nto	disease				24a. Wes a parform		av	ere eutopsy findings allabia prior to empletion of causa daeth?
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25. Was case referred to medical axaminer?					26. Plece	of Death	(Check only on	/		
1 Yas 2 No	Hospital: 1   Inpatient	2 ER/0	utpatient 3 DOA	Oth	ar: 4 Nu	irsing Ho	ma 5 Rasida	ince 6 🗆 Ot	har (Specif	fy)
27. Mannar of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	28a. Data of Injury (Month, Day )		Tima of 280 Injury M	e. Injur Wor			28d. Dascribe ho			
3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida detarminad	28e. Place of Injury building, atc.	/ - At home, fe (Specify)	erm, straat, factory,	office			28f. Location (St. City or Town		ber or Rura	al Route Number,
29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	sician: To the best of oner: On the basis of each manner state	xaminetion an	a, daath occurred et nd/or Invastigation, ir	tha tin	na, data an pinion, daa	d place, a	and dua to the ca ed at tha tima, de	ause(s) and mata and place,	anner es s , end dua to	statad. o tha causa(s)
29b. Signature and title of certifier	mid mainler state		29c. 1	Licens	a number		25	9d. Date signe	ed (Month	Day, Year)
> MsQ	hous-	W				21				
30. Name and eddress of person who could be a CMAN		th (Item 23e)	(Type, Print) 78	34	SBW	aku	rood R	2106	Suit	28,1998
31. Data filed (Month, Day, Year)	32. Ragistrar	s Signatura	4				1		<u> </u>	

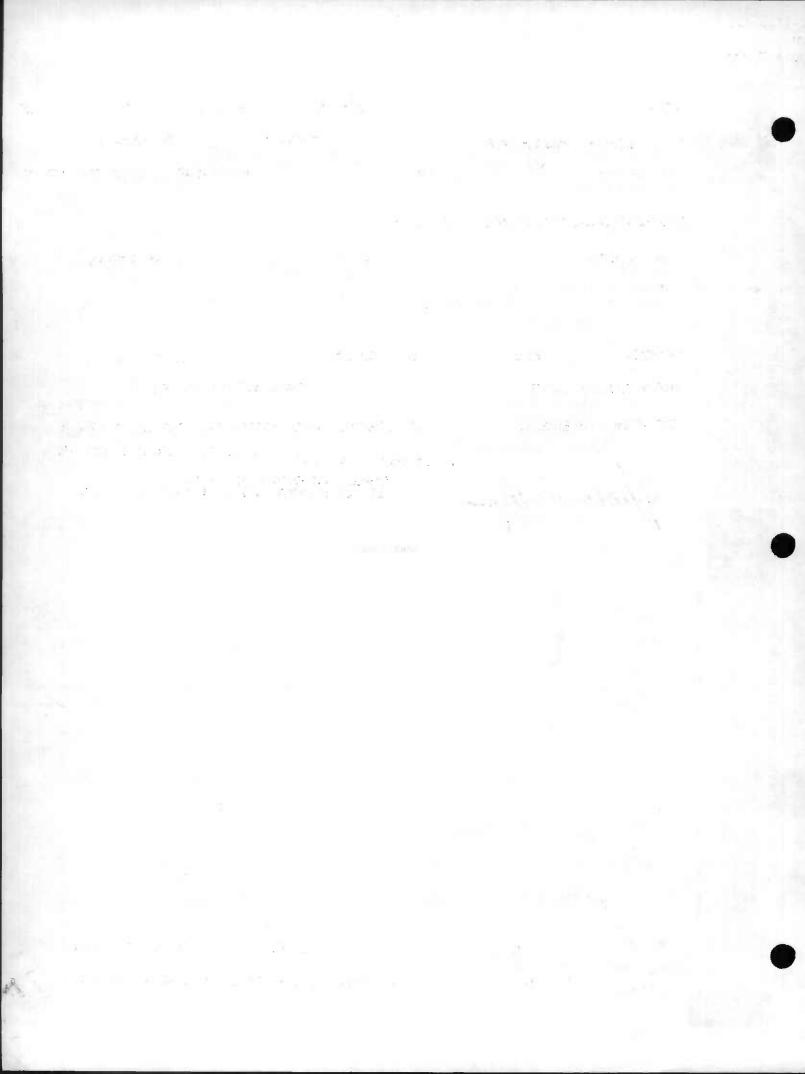
DHMH 16 Rev 6/95

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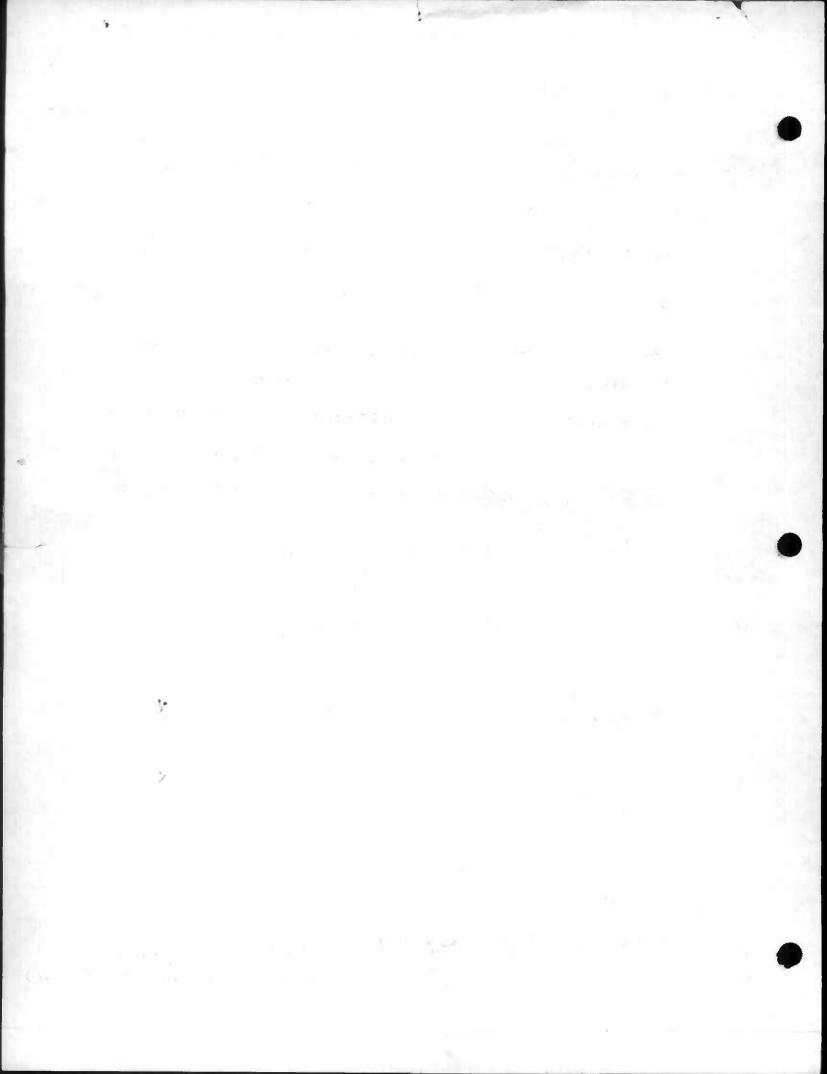
mel MS: #23	PART I, II, PE	R MEO G76			epartment of Certificate				Reg. No.	2	666 <b>6</b>
Physician	Decedent's Neme (i	First, Middle, Le	est)					2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
/Medical Examiner	LOUIS 4a Facility Neme (If no	ot institution, giv	ve street end number	)	ROM		own, or Lo	August		998 of Deeth	10:25 A.M
	2506 Yorkw	av. Apa	rtment A			DUNDA	ALK		Balt:	imore	
uneral	5. Social Security Num	ber 6. S	Sex 7. A	ge (In yrs. last birt	Months	rear If Under Peys Hours	r 24 Hrs. Min.	8. Dete of Bird (Month, De		9. Birthp	lece (State or Foreign try)
irector	220-52-386	3	1⊠ M 2□ F	49	rs.			8/15/19			ORK STATE
*	Usuel Residence of De 10e. Stete 1	ob. County		10c. City, Town	or Location					1	Od. Inside City Limits
notified at											1 ☐ Yes 2 ☐ No
Director	MARYLAND E		RE COUNTY	DUNDA	LK 10f. Zip Ci	via			10g. Citizen of N	What Coun	to/2
2 0					101. 2.0				Tog. Onizon or		.,.
Funeral	2506 YORK	WAY	12. Was Deceden	Ever in U.S.	2122		rigin? (Spe	ecify Yes or No	UNITED 14. Had	STATE	indien,
Fun	12 Never Married	2 Married	Armed Forces	?	13. Was Deceder If Yes, specify	Cuben, Mexica	in, Puerto	Rican, etc.)	Blac	ck, White,	
þ			If Yes, Give	UNKNOWN	1 ☐ Yes 2 ☑	No Specify	<i>r</i> :		Specify	·· WH]	TE
		. Decedent's E	ducation		Decedent's Usuel (	Occupation			16b. Kind of B		
Die	Elementery/Seconda		ede com <i>pleted)</i> College (1-4or	5+)	(Give kind of work life. DO NOT use	retired)	St Of WORK	ng			
Completed	UNKNOWN		NONE		UCK_DRIVE	R.			TRUCKIN	G BHS	TNIEGG
Be	17. Fether's Neme (Fin	st, Middle, Last	"			18. Moth	er's Name	e (First, Middle,	TRUCKIN Meiden Sumen	10)	TITLOO
0	EDWIN PROC	TOR ROM	MEL			ERM	IA PA	ULINE H	IOLLEN		
	19e. Informent's Nem	Aletionship (	(Type, Print)	19b.	Meiling Address (5	treet end Numb	ber or Rura	al Route Numb	er, City or Town,	Stete, Zip	<sup>Code)</sup> 21157
	AUNT-ANNA		EDER	51	5 TREMONI Disposition (Name	PLACE	UNIT	4 WEST	MINSTER	MAF	
	20e. Method of Dispos		Removel from State	COTTLOCAT	orematory or other	or plece)		/28/98	CATONS		
once.	4 Donetion / 5				crematory	, inc.	10	/20/90	CATONS	ATTTE	: / FID
once.	21. Signeture of une	ral Service Lice	nsee			FUNERA		ME, P.A			
	year	then N	· Hausen			CH RAVE			WSON, M	D 21	.286
	23a. Part /Enter the	diseese, or com allure. List only	plications that cause one cause on each	ed the death. Do n line.	ot enter the mode of	f dying, such e	s cardiac o	or respiretory e	rrest,		Approximete Intervel Between
n			V	0400740 45	OUNTUMES						Onset end Death
al er	Immediate Cause (Fin disease or condition resulting in deeth)	aı	е	CARDIAC AF	KHYIHMIA						
e e				Due to (or es e o	onsequence of):						
al Examiner	Sequentially list condi	tions,	b	Due to (or es e c	onsequence of):						
		ng	C								
Ė	resulting in death) Les			Due to (or es e c	onsequence of):						
e e			d								
Physician/M	Part II. Other significa	nt conditions	contribution to death	but not reculting to	the underlying ac-	e given in De-	1	23h Did	tobacco use co	ntribute *	the cause of death?
Physi	MALNUTRI		combuting to death	out not resulting in	the undertying cau	ae Aireil III Leil			Yes 2 No		. /
by P		1011	0-								,
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Completed								180	Yes 2□ No		Yes 2 No
BeCc		to medical				26 Plea	e of Deett	h (Check only		D	22.10
0	exeminer? 1⊠ Yes 2□ No		Hospital:	ient 2 ER/Out	petient 3D DOA	Othor		**	dence 6 □Ott	er (Specif	y)
-	27. Manner of Death		28e. Dete of In	ury 28b. T	ime of 28c	injury et Work?	-		how injury occur		
atio	1 Accident	5 Pending investigation	(Month, D	by rear) If	jury M	1 Yes 2	] No				
Certification:		6 Could not be determined	Zee. Place of II	njury - At home, far	m, street, factory, c	ffice		28f. Location ( City or To		ber or Rure	Route Number,
	000 00 000	7.00-011	total =		4						
edicai			nyeician: To the bes miner: On the basis end menner s	of examination end							
Medical Certifical	29b. Signeture end title	e of certifier	ond monitor s		29c. L	icense number			29d. Date signe	d (Month,	Dey, Yeer)
3	D.		10/12			OCMI	P		August	12	1998
	30. Neme end address	my d	completed assess of	dooth (thom 02=) (	Tyrno Print\	O.C.M.I	٠.		August	14, -	
	Denne	5	Chute us	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	111 Peni	Street	t, Ba	ltimore	e, Maryl	and 2	21201
	31 Date filed /Month	20 C-	- INTER	4 . 01	111 1011		_,				

State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1.	Decedant's Nama (First, Middle, Las	)		Certific	01			2. Data of De			3. Tima of Deat
sician		Lillian	5	+u	bbs				Augus	+ 27, 1	Yaar 998	11:35 /
edical miner	4 -	Facility Nama (If not institution, giva	street and number)	,			4b. City, To	wn, or Lo	cation Deat			1.327
iiiiei	r	1615 €. 25	th St				ba	16		N/A	4	
ral or		Social Security Number 6. Se 20-03-4941	7. Aga M 254F 7		st birthday) If Un Yrs. Monti	der 1 Year ns Days	If Undar Hours	24 Hrs. Min.	8. Data of Bir (Month, Di MAR 21	th Year) 1921	9. Birthp Coun	lace (State or Fore
		a. Stete 10b. County		10c City	Town or Location						1	0d. Inside City Lin
ctor	-	MD 100. County	N/A	Too. Oily,	TOWN OF EGGLION	BA	LTO					XXYas 2
Funeral Director	10	e. Street and Number 1615 E 25th ST			10f.	Zip Coda 212	213			ntry?		
Ď		. Marital Stetus  1 □ Navar Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Wes Decedant E- Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:			cedant of I pecify Cub 2 1 No	lispanic Or an, Maxice Specify		ecify Yas or No Rican, atc.)	Blac	e - Americ k, Whita, BLA	
Completed		15. Decedant's Edu (Specify only highast grad			16a. Decedant's U (Giva kind of lifa. DO NO	sual Occup work dona	ation during mos	st of work	ing	16b. Kind of Bu	sinass/Ind	dustry
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To Be		JOHN JAMES					SAF	RA H	ENRY	, Maideri Surrain	a,	k
	19	ea. Informant's Name/Ralationship (7) ROSALIND BROOKS			19b. Mailing Addr 7 HAYL	ass (Street DCK (	end Numb	er or Run 301	a <i>l Rou</i> ta Numb BALTO	er, City or Town, MD 21	Stata, Zip 236	Coda)
	20	a. Method of Disposition  1 Burial 2 Crametion 3 1  4 Donation 5 Othar (Specify,		car	nce of Disposition (matary, cramatory)	or othar pla		9	Data - 2 - 98	20c. Location - CROWN		
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once.		Mating	1/11	1/2	1129	N. (	CARO	LINE	ST	BALTO,	MD2	1213
	2	3a. Part1. Enter the disease, or comp shock, or heart failura. List only of	lications that caused t	he deeth.	Do not antar the r	node of dyi	ng, such es	cardiac	or raspiratory	errest,	Ţ	Approximata Intarval Batween
in	1	shock, or near failura. List only o										Onset end Deeth
al	In	nmediete Cause (Finel saasa or condition	My	OC a	rdul	(h	tas	cha	200			
er		sulting in death)	1 1	Due to (or	as a consequance	ef):	-				i	
in a			. Hy	per	tension	1					1	
Examiner	S	equantially list conditions,	V	ua to (or	es a consequança		1				1	
	Gausa. Entai Orioanyng										1	
ician/Medical	ra	at Initiated evants sulting in daath) Last			as a consequence			•			1	
-			d. Hy	per	chole st	1016	mic	2				
Clar			V		and the second second		Landa Bara		nah Did	tahaasa was sa	ndelbude de	a the series of de
Physician/M								1.		Yes 25 No	obacco use contribute to the cause of de res 2 No 3 Probably 4 Uni	
eted by Physician/N									24e. Wes	s en eutopsy ormed?	ev	ere autopsy finding eilable prior to empletion of cause
Completed									10	Yes 2 No		daath? □Yas 2□ No
Be	25	i. Was casa rafarred to medical axaminar?				10		a of Daar	h (Chack only	ona)		
2		TE Yes ZIANO				DUA		ursing Ho		idence 6 □Oth		fy)
itlon:	27	7. Mannar of Daath 1 Natural 5 Pending 2 Accidant Invastigation	28a. Data of Injury (Month, Day		28b. Tima of Injury M	28c. Inju Wo	nyat ork? ]Yes 2 ⊑	]No	28d. Describe	how injury occur	red	
Certification:		3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Placa of Inju- building, atc.		ne, farm, street, fac	tory, offica	4			(Straat and Numb own, Stata)	er or Run	al Routa Number,
edical (			sician: To the best of ner: On the basis of and mannar stat	axaminatio								
Medical Certification:		bb. Signatura and titia of cartifiar	Hre	rof	KNO	29c. Lican	sa numbar	14		29d. Data signa	d (Month,	Day, Yeer)
			0	ath /!!		- 1	- 1 1			101	110	
	30	Nama end addrass of person who co	omplated cause of de	atn (Itan)	23a) (Typa, Print)	1 1	hd -	2,22	4.1	INA FI	FIND	rett, N



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg.	No. 70 2000											
Physician	1. Decedent's Neme (First, Middle, Last)	2. Dete of Deeth Month	Dey Yeer 3. Time of Death											
/Medical	Emma B. Schmelyun	AUGUST	28 1798 0.											
Examiner		or Location of Deeth	4c. County of Deeth											
	The state of the s	lyn Park	Anne Arundel											
Funeral Director	5. Sociel Security Number  6. Sex 1 M 2X0 F 7. Age (In yrs. lest birthday) Wonths Deys Hours 1  Usuel Residence of Decedent	Hrs. 8. Date of Birth (Month, Dey, You Aug. 5, 1	9. Birthplace (State or Foreign Country) 926 Baltimore											
pue *	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits											
with the Maryland a or 28a-1 show Le notified at	Manual and Anna Annadal Clan Burnia		1 □ Yes 2 X No											
or 28a-fe	Maryland Anne Arundel Glen Burnie  10e. Street end Number 10f. Zip Code	100	. Citizen of Whet Country?											
D Por														
death w	102 Dickens St. 21061		nited States  14. Race - American Indien,											
UZO urs etter al', or ite canding	11. Maritel Status  1 Never Married  1 Never Married  2 Married  3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces?  1 Yes, 2 No If Yes, Sive Yeer or Detes:  13. Wes Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, P  14. Wes Decedent Ever in U,S. Armed Forces?  15. Wes Decedent of Hispanic Origin If Yes, specify Cuben, Mexican, P  16. Yes, Sive Yeer or Detes:	r (Specify 165 of 140- uerto Rican, etc.)	Bleck, White, etc.  Specify: White											
1 21215-0 led within 72 ho yglene. her than "nature nt, the Medical Completed	15. Decedent's Education 16a. Decedent's Usuel Occupetion	161	b. Kind of Business/Industry											
Z Tithin 7	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	Working												
N pas N	12 Homemaker		Own Home											
O TIES O	17. Fether's Name (First, Middle, Last)  18. Mother's	Name (First, Middle, Mai	den Sumeme)											
yian would be Mental arked o	Philip Grace De	lla Houc	k											
re, Maryis s 1 and 2 should f Health and Mar tem 27 is marke other treumetic	19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street end Number of	r Rural Route Number, C	ity or Town, Stete, Zip Code)											
	Jack Schmelyun/Son 102 Dickens St.	Glen Burn	ie Md.21061											
item 2	20a Mathod of Disposition 20h Place of Disposition (Name of		c. Location - City or Town, Stete											
2 5 5 5	1 Burial 2 Cremetion 3 Removal from State 4 Donetton 5 Nother (Specify)  A donetton 5 Nother (Specify)  Meadowridge Mem.Park	9-1-98 D	orsey,Maryland											
permit. Pe Depertment Important: any injury	21. Signefure of Funeral Social Licenses  22. Name and Address of Facility Ambrose Funeral Home, Inc. 21227 1328 Sulphur Spring Rd. Arbutus, Maryl													
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es car shock, or heert feilure. List only one cause on each line.		Approximete Interval Between											
Physician			Onset end Deeth											
/Medical	Immediate Cause (Final disease or condition ARTERIOSCIENOTIC CAP	2DIO VASC	WLAR 2 YEARS											
Examiner	Immediate Cause (Final disease or condition resulting in death)  Bue to (or es e consequence of):  Due to (or es e consequence of):													
executed in all the side of th	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Lest  b													
ifficate be ex g physician es the buriel														
- DO 0														
requires that the death cert requires that the death cert seen signed by the ettending hould be deteched for use.	d		1											
death death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did toba	cco use contribute to the cause of death?											
v requires that the de been signed by the should be deteched leted by Physic		-	acco use contribute to the cause of death:											
	LORGICO VISCULAR HEELDENT	_	ZEINO CENTOSCO, CENTOSCO											
d by did by	DEMENTIA	24a. Wes en e	eutopsy 24b. Were eutopsy findings											
The law require take has been single page 2 should Completed	newpolit	performe	completion of cause											
Vital necords, sician: The law requires the certificate has been signed inector, page 2 should be completed by			of death?											
The Late he cate he page		1 ☐ Yes	2 2 No 1 Yes 2 No											
Physician: this certified rel director,	exeminer?	Death (Check only one)												
- 5 00		ng Home 5 Residence	e 6 □Other (Specify)											
e fe fe	27. Manper of Deeth  1 Natural 5 Pending  28a. Dete of Injury (Month, Dey Year)  28b. Time of injury work?  1 Yes 2 No	28d. Describe how	injury occurred											
OIVISION OI or Attending Physelter death. Director: After this d in by the funeral di ertification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)											
ne Hospital ne Funeral pletely filled	29a. Certifier (Check only one)  1 Certifying Phyeicien: To the best of my knowledge, death occurred et the time, date end p 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth of end menner stated.													
To the com	29b. Signeture and title of certifier  29c. License number  D 2177		Date signed (Month, Day, Year) SUST 28 1998											
り	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SURA NUNDRA WO 3001 S HAN	over st	BACIMENEZIZZ											
State	31. Date filed (Month, Day, Year)  32. Begistrar's Signeture													
Registrar	SED 0 1 1998 Server A													

Sand James Sale

## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

11110	Decedent's Name (First, Middle, Last	otate of iviaryial		icate of			leg. No.	26669
Physician						Month	Day Ye	180
/Medical	PATRICIA ELEANOR				4b. City, Town, or L	AUGUST	3) 199 4c. County of E	18 1.00
Examiner	4a Facility Neme (If not Institution, give					OCATION OF DOGUN		
	Fallston General  5. Social Security Number 6. So		. last birthday) If	Under 1 Year	Fallston	8. Dete of Birth	Harfor	
Funeral Director		DM 2ØF 67		onths Days	Hours Min.	Oct. 9,	1930 N	Birthplaca (Stete or Foreign Country) Auryland
tar deeth with the Maryland Herra 23a or 28a-1 show for must be notified at Tuneral Director	10a. Stete 10b. County		ity, Town or Locati	on	177		10d. Inside City Limits 1 ☐ Yes 2 X No	
vith the Mar or 284-1 al	Maryland Harford		sel Air					
Dir.	10a. Street and Number	6 1		Of. Zip Code			log. Citizen of Wha	t Country?
e 23	1818 Bramble Broo		15 12 110	21015		anifu Van as Na	U.S.A.	American Indien
filed within 72 hours after deeth with the Maryland Hydione. Hydione. Hydione ther than 'patural', or terms 23s or 28s-f show wit, the Madical Exempter must be notified as Completed by Funeral Director.	11. Merital Status  1 Never Merried 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, V	White, etc.
natural, or page leted by F	15. Decedent's Ed		16a Decedent	's Heuel Occur	etion		16b. Kind of Busine	
ed within 72 ho ygjene. er than "naturi t, ne tricient	(Specify only highest gree	fe completed)	(Give kind	of work done	eation during most of world)	king	TOD. INITIO OF DUSIN	osa moustry
Hygiene. ther then out, tre the	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		Service			Departmen	nt Stone
be filed wal Hyging other event, Be C.	17. Father's Name (First, Middle, Last)		1000	OCTORECE C			Maiden Sumeme)	D. Corte
2 should be fit and Mental H is marked off summit ever aumatic ever	Francis Mancheste	h			Eleanor	Hughes		
2 should be and Menta is marked aumatic or	19a. Informent's Name/Relationship (7		19b. Mailing A	ddress (Street			r, City or Town, Ste	te. Zip Code)
ロモトロ	Patricia A. Sisso						e Air, MI	
f Heel fem 2 other	20e. Method of Disposition	20b.	Place of Disposition	n (Neme of			20c. Location - City	
00	1 Buriel 2 Cremation 3	Removel from State	cemetery, cremeto			0/2/06	D-0 A:	11 - 4 - 10 - 1 - 1
	4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen:			morual ame end Addre		9/3/98	Bel Aur,	Maryland
permit. Pag Department important: I any injury o	Trobul fran	UL	Sch 610	imunek W. Mac	Funeral Phail Ro	Home of ad. Bel	Bel Air, Air, MD.	Inc. 21014
	23a. Part1. Enter the disease, or composhock, or heart failure. List only	licetions thet caused the dee	th. Do not enter th	ne mode of dyir	ng, such es cardiac	or respiretory err	est,	Approximete Interval Between
lan and urial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	or es e consequen					
at the death certificate be d by the attending physicic etached for use as the bu Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (	or as e consequen	ca of):				
deat ed fo	Pert II. Other significant conditions co	ntributing to death but not re-	sulting in the under	rlying cause giv	ren in Part t.	23b. Did to	obacco use contril	bute to the cause of death
E 90 >						1 D Y	7es 2□ No 3[	Probably 4 Unknow
aw requires been 2 shou						24a. Wes e perfor	en eutopsy med?	4b. Were autopsy findings available prior to completion of cause of death?
The late he page						1 🗆 Y	es 2 PNo	1 ☐ Yes 2 ☐ No
certificate rector, pa	25. Was case referred to medical examiner?				26. Placa of Dea	th (Check only or	ne)	
S S D	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Ott	er: 4 Nursing H	ome 5 Resid	enca 6 Other	Specify)
	27. Manner of Deeth 1 ØNetural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of tnjury	28c. tnju	y et k?	26d. Describe h	ow injury occurred	
death ctor: y the	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street,	M 1 🗆	Yes 2□No	28f. Location (S City or Tow	itreet end Number o n, Stete)	or Rural Route Number,
Hospi 4 hou Funer tely fill	29a. Certifier 1 Certifying Phy (Check only anel)	stcian: To the best of my known ar: On the basis of examinating and manner stated.	owledge, death oc etion end/or invest	curred at the tir igetion, in my c	ne, date and place pinion, deeth occu	end due to the c rred at the time, o	ause(s) and manne date end place, and	er es stated. I due to the cause(s)
within 2 To the comple	29b. Signature and title of Section	^	1.0	29c. Licens	e number	_ 2	29d. Date signed (A	Month, Day, Year)
1	John Fred	want	(h)	123	31775	1	Jubust	31, 1998
6	30 Name and address of person who c	ompleted cause of deeth (Ite	m 23a) (Type, Prin	10012 Aus	TON	nary	AND	21047
State	31. Date filed (Month, Dey, Year)	32 Registrer's Sign	ature 4	1	-			

DHMH 16 Rev 6/95

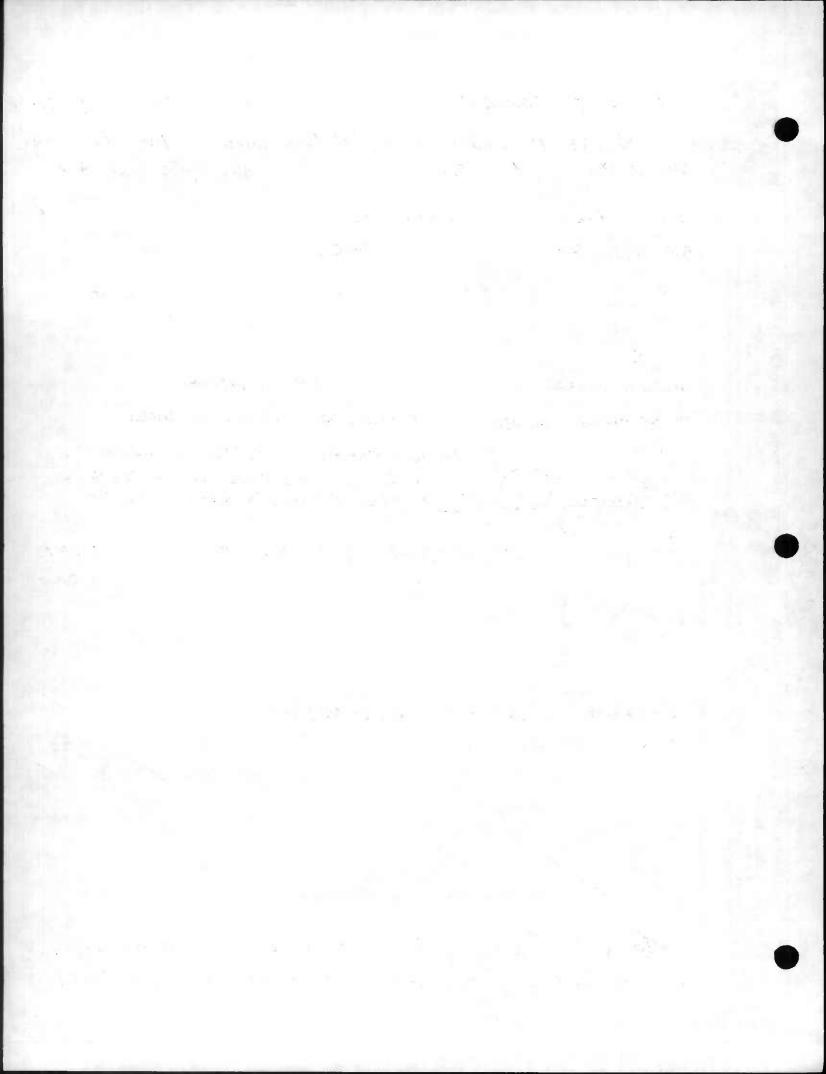
Patricia

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Registrar

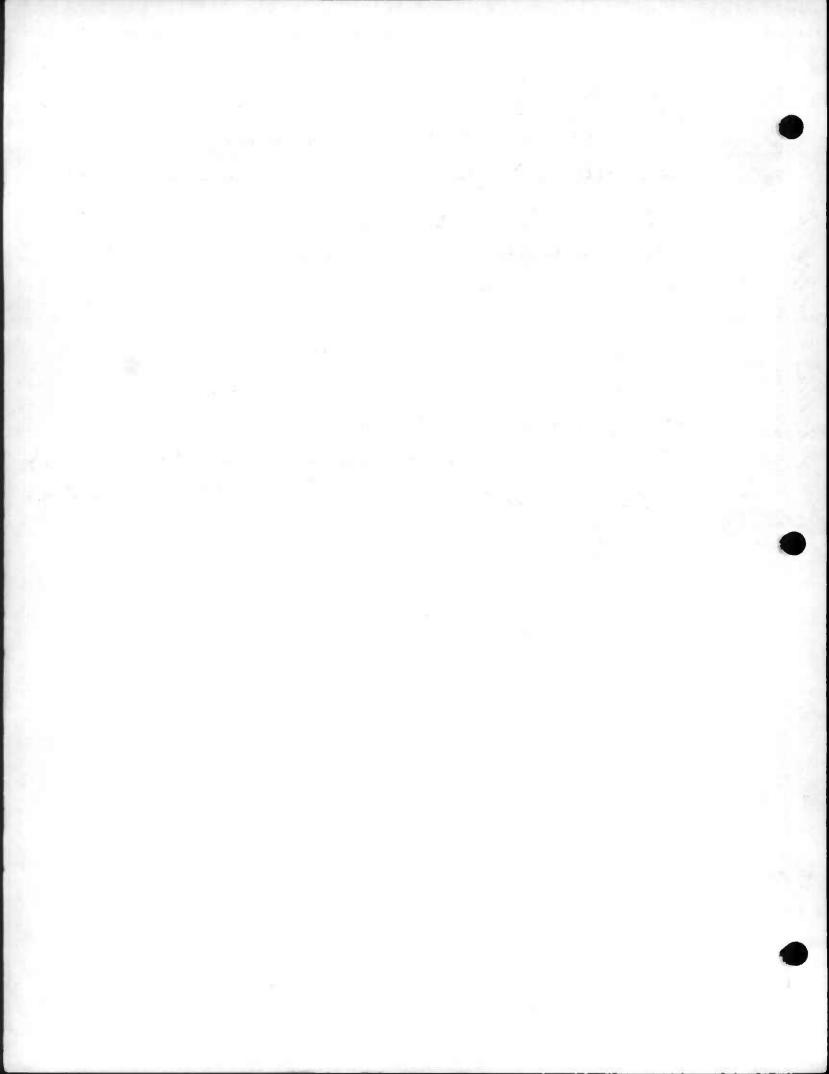


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** ugust /Medical 4a. Facility Name (If not institution, giva streat and numbar) 4b. City, Town, or Location of Opath 4c. County of Death **Examiner** Paryland General Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 2 🕶 F Days 60-8629 720-Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Md Baltimore Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Park Heights 4615 Items 23a 4.S.A 21215 Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Yes 2 Who Yes, Give Year or Dates: 1 Naver Married 2 ☐ Married "natural", or Specify: Black 1□ Yes 2M No by 3 Widowed 4 Divorced Completed permit. Peges 1 and 2 should be filed within 72 in population of Health and Mental Hygiene. Important: If Nem 27 is marked other than "neture any injury or other traumatic avant any logues. 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LINK LINK 12 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) UNK UNK 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) GrEEN Spring 4615 Park HEIGHTS AVE NUTSING 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Voshell MEM. Park Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility acility not Funera Tw. North the Prode 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner consequence of): Heart Failure attending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be detach 3 Probably 4 Unknown 1 Yes 2 No Records, by 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 26. Place of Death (Chack only ona) Hospitel: 1 Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Al completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Numbar, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aryland General Hospita Sanghari, preet 31. Date filed (Month 32. Begistrar's Signature State Registrar

**DHMH 16 Rev 6/95** 



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items:18,19a,b,20c per F.H G-763 9/1/98 reb Certificate of Death Reg. No. 1. Decedent's Name (Fitst, Middla, Last) 2. Dete of Deeth 3. Tima of Death ZZAN Month Ugus 24, 1998 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Baltimore Northwest Hospital If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 7. Aga (In yrs. last birthday) if Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 X Days Yrs. 76 214-18-0168 Usual Residence of Decedent 10d. tnside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2√ No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? Apt 2-A 12. Was Decedent Ever in U,S. Armed Forces? U.S.A. 21144 4 Korado Court Was Decedent of Hispanic Origin? (Specify Yas or No-tif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Giva 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Detes: Black 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) NA 8th grade Housewife Home 18. Mother's Name (First, Middle, Maiden Sumame) BRYANT 17. Fether's Name (First, Middla, Last) Mary Bryandt Jeremiah Fennell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) SYLVESTER SNEED Korado Court apt 2-A Md 21144 4 Korado Court Apt 2-A, vern, 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cematery, crematory or other place) Dete 20c. Location - City or Town, Stete TOWSON 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. 22. Name end Address of Fecility 8/29/98 <del>Dulancy</del> 21. Signature of Funaral Sarvice Licensea March F/H West 23a. Part1. Entar tha disaase, or complications that caused tha death. Do not antar shock, or heart feilure. List only one ceuse on each line. 4300 Wabash Ave, Baltimore Md ntar tha moda of dying, such as cerdiac or respiratory arrast, 21215 Approximate Interval Between Onset end Death immediate Ceuse (Final disaasa or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a Stete

MD

Director

Funerai

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Completed

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**Funeral** 

Director

th and Mantal Hygiana. 7 is marked other than "naturel", or items 23a or 28s-f show traumstic event, the Medical Evantina must be notified at

the Maryland

daath with

filed within 72 hours after

Pagas 1 and 2 should be file mant of Haalth and Mantal Hight: If from 27 is marked oth

altimore,

item 27

permit. Paga Department of Important: If any injury or once. = 6

> Examiner physician and tha bunal-transit attanding pt the signed by this id be datached cartificata has lirector, page 2 s director, this funarai

requires that the death cartificate be executed

Box 68760

P.0.

Records,

Division of Vital

Attending

death

To

Physician/Medical þ Completed Be P Certification:

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings aveilable prior to completion of cause 24e. Wes en eutopsy

1 ☐ Yes 2 ☐ No 1 Yes 2 No

25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Day Year) 27. Manner of Beeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Yes 2 No

1 Maturel invastigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steled.

29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertit 29c. License number

d eddress of purson who completed ceuse of deeth (Item 23a) (Type, Print)

Daniel Malone, M.D. 30. Neme end eddress o

State Registrar

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31. Dete filed (Month, Day, Year) SEP 1 1998 32. Registrer's Signeture

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** 12:00 NOON Sophia Mary Ida Snipe August 28 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kenasaw nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | B. Data of Birth (Month, Dey, Year | 8-13-1900 Birthplace (State or Foreign Country)
 Md 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2□xF Yrs. 213-34-1162 98 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or frame 23s or 25s-f show the Medical Examinar must be notified at N/A Baltimore XIX Yes 2 □ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3913 Barrington Road 21207 USA Funeral or Items : 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. flied within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes Q No Specify: Specify: Black Completed by XØ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Hair Salon Beautician 12th grade vears . Pages 1 and 2 should be filed viment of Health and Mental Hygis lant: if Item 27 is marked other to jury or other traumatic event, in Baltimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Surname) 8 Robert E. Gross Rosetta Sparrow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Sagra Road Baltimore, Md 21239 19a. Informant's Name/Relationship (Type, Print) Carolyn Collins - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☐ Rurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Docetion 5 ☐ Other (Specify) Department of Important: If any injury or page. Md National Memorial Park 9-3-98 Laurel, Md 21. Signatu of Funeral Service Licenses 22. Name and Address of Fecility March F/H West the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximately the disease on aech line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, engestiv Physician/Medical the t Qua lo (or as e consequence of) U80 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed this certificate has 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: director. 89 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No Other: Mursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) funaral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation I Director: Aff 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 T Homicide 6 To the Hospital
within 24 hours a
To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to tha cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at tha time, date end place, and due to tha cause(s) end manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) 01832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4660 Wilkens Are Ralfo md 21229

State

Registrar

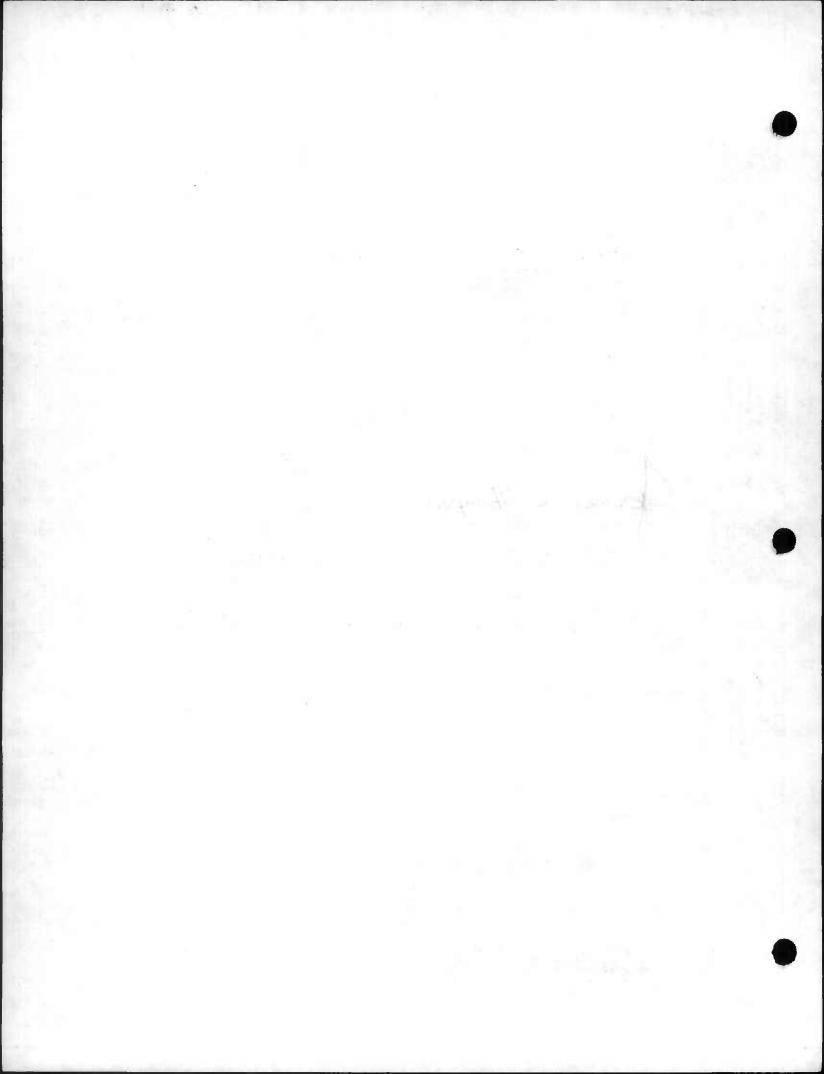
31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

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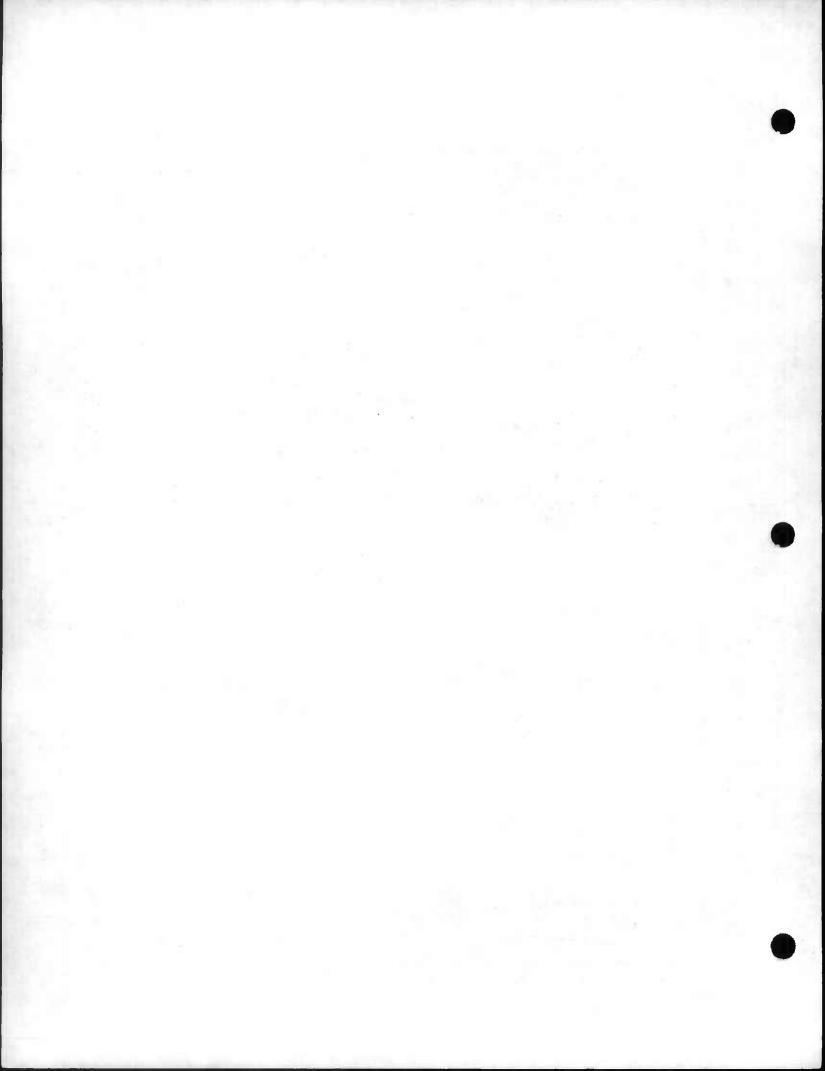
1998



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Pauline Ruth Sutt 29, 1998 6:20 am August /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 942 Thompson Blvd. Baltimore Essex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF Months Hours 218 10 1243 79 Director Dec. 27, 1918 Maryland Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Baltimore Directo Essex 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 942 Thompson Blvd. 21221 USA Funeral deeth 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritel Stetus Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 Peges 1 and 2 should be filed vener of Heelth end Mental Hygic int: If Item 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Kenneth Waggner Audrey Hand 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 Department of Heelth e Important: If Item 27 is any Injury or other tra once. 942 Thompson Blvd. Baltimore, Md. 21221 Robert Sutt (Son) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Holly Hill Mem. Gardens 8/31/1998 Baltimore, Co. Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetyre of Funerel Service Licenses 22. Name end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** Immediate Cause (Finel diseese or condition resulting in deeth) /Medical Non-Hodokin's 12 mo. Examiner Examine physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initioled events resulting in death) Last Due to (or es e consequence of) Box 68760. the death certificate be Physician/Medical Due to (or es e consequence of) 980 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The lew requires that of Vital Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? page 2 s 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No To the Rospitar or Attending Physicien: within 24 hours after defin.
To the Fundate Director. After this certifical completely filled in by the funeral discount. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No edical Certification: To 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation injury 1 XNeturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. (Check of one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number m.D. D45390 8/30/98 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 6830 HOSPITAL DR. # 206, BALTIMORE, MD 21237 C. M) LOEM OYM 31. Dete filed (Month, Day, Year) 32. Registrer's Signafu State 1 1998 SEP Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Garnet Amanda Snyder August 28, 1998 5:00 am 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 35 Cardinal Rd. Baltimore Essex If Under 24 Hrs 5. Social Security Number If Under 1 Yeer Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Deys Hours 1□M 2/2 F Months 213 78 9174 80 August 25,1918 West Virginia Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Cardinal Rd. 21221 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Maritel Status 1 Never Married 2 Merried Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 □Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 9 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Burtis Carpenter Eppie James 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Peggy Gilroy (Daughter) 35 Cardinal Rd. Baltimore, Md. 21221 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State Holly Hill Mem. Gardens 8/31/1998 Baltimore Co., Md. 5 Other (Specify) 4 ☐ Donation red Funger Service 22. Name end Address of Fecility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. at caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximete tritervel Between Onset end Death Immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to 24a. Wes an autopsy performed? evailable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

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To the Hospital of within 24 hours af To the Funeral Di complataly filled in

Tha law requires that the death cartificate be axecuted

P.O. Box 68760,

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Division

**Physician** 

/Medical

**Examiner** 

10e Stete

**Funeral** 

Director

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permit. Pages 1 and 2 should be filed wit. Department of health and Mantal Hygiens important: if item 27 is marked other that eny injury or other treumatic event, the Lance.

Director

Funeral

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Completed

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72 hours after

Baitimore, Maryland 21215-0020

Examin physician and s tha burial-trans Physician/Medicai Completed paga 2 s Be edical Certification: To

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29a. Certifier

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Menner of Deeth

5 Pending investigation 1 (3 Natural 2 Accident 3 ☐ Suicide 6 Could not be 4 \( \text{Homicide} \)

26a. Dete of Injury (Month, Pax) Pleca of tnjury - At home, term, street, tactory, office building, etc. (Specify)

1 Inpatient

Hospital:

Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 28c. Injury et Work?

1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

5 ☐ Hesidence 6 ☐ Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Numbarl City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated.

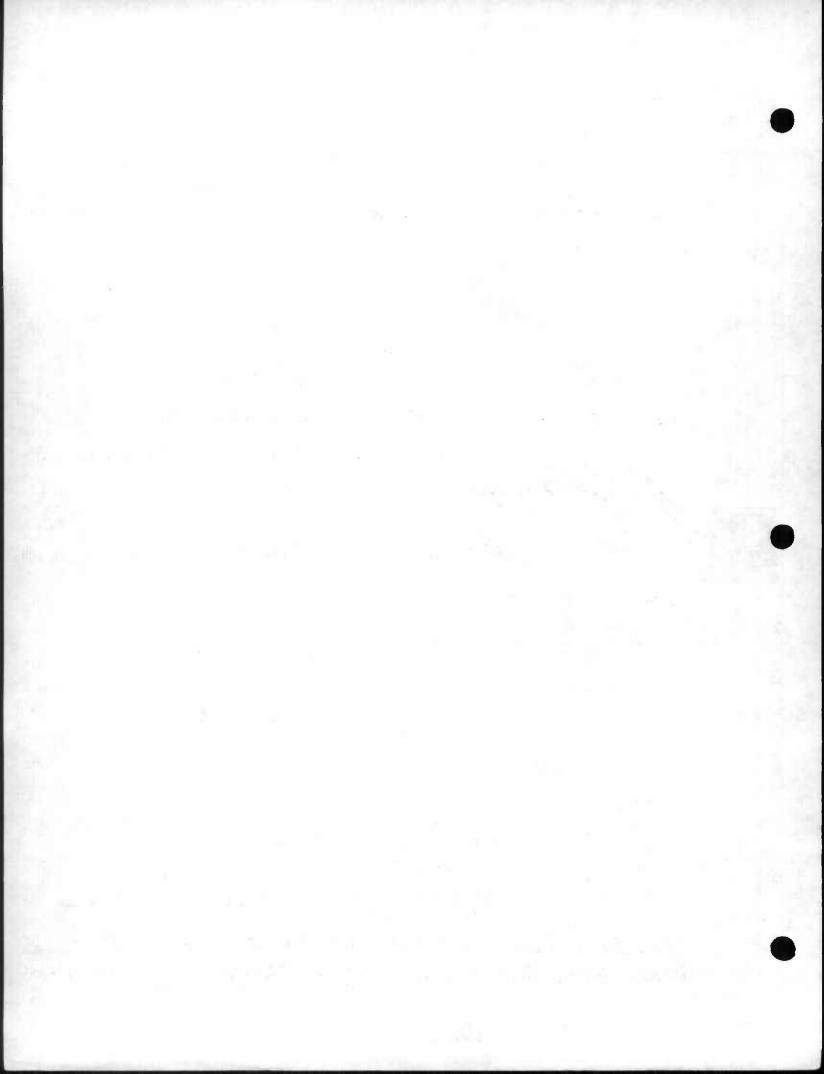
2 Medicat Examtner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Laudles MD

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Dete tiled (Month, Dey, Year)

32. Registrer's Signeture



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State of Maryland / Department of Health and Mental Hygiene

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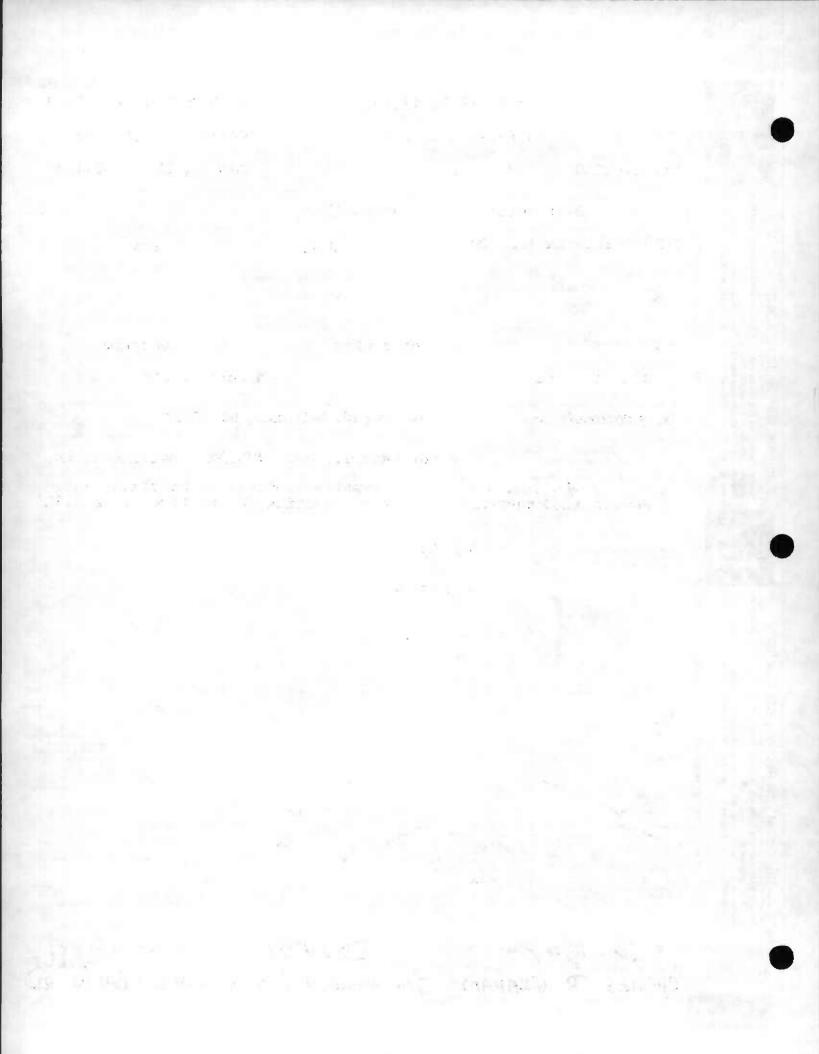
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death AUGUST 29,1998 **Physician** 7:15 PM Elsie Beall Schilling /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Deeth **Examiner** Frederick Villa Nursing Center Catonsville Baltimore 8. Dete of Birth (Month, Day, Year)
JUNE 22, 1909 If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Deys Months 1□ M 2 F Hours Maryland 212-01-2330 89 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Hygiena. sther than 'natural', or Nems 23a or 28a-f show ent, the Medical Examinar must be notified at MD Baltimore Catonsville 1 Tyes 2 No Director 10g. Citizen of What Country? 717 Maiden Choice Ln., #305 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Itema 23a or 3 any injury or other traumatic event, the Medical Examiner must be no 21228 IISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surmame)
Minnie L. UNK. 17. Father's Name (First, Middle, Last)

John T. Bean Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Harry Hoffman/friend 405 Gun Rd. Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/31/98 Baltimore, MD 22. Name and Address of Fecility 21. Signature of Funeral Service Licent Cremation Society of Maryland, fine.

Edward A creporchik 299 Frederick Rd. Baltimore, MD 21228

23a. Part1. Enter the disease, o complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, history a Battery Cremation Society of Maryland, Inc. Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest attanding physician and for use as the burial-tran to (or as a consequence of) sion of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) use as t signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Deen certificate has t lirector, page 2 s 1 Yes 2 No 1 Tyes 2 No 25. Was cese referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 5 Pending investigation NID NA 1 Yes 2 Accident 6 Could not be determined 28f. Locetion (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) afte D 4 \ Homicide 12 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and fitle of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIDEN CHOICE LANE - BALTO GRAHAM -7/6 31. Date filed (Month, Day, -Year) 32. Registrar's Signature State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

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	<b>6</b> 1		1. Decedant's Nama (First, Middla, Last)							2	Data of Dee	eth Day	Yaar	3. Tima of Death	
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	Examin	er	4 Fecility Name (If not institution, give s 4 101 GARRISON BLV					4		vn, or Loca LMORE	tion of Deeth	4c. County			
-	Funeral		5. Social Sacurity Number 6. Sax	7. Age	(In yrs.	last birthday)	If Under Months		If Under 2	24 Hrs. g	. Data of Birt (Month, Da			placa (Stata or Foreign	
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	or 28	Director	10e. Street and Number 4101 GARRISC	N POULEAY	DD		10f. Zip	Coda	2121	5		10g. Citizen of What Country? U.S.A.			
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5	Peges 1 sent of H nt: if Itan		20a. Mathod of Disposition  20b. Place of Disposition (Nama of cemafary, cramatory or other place)  20c. Location - City of cemafary, cramatory or other place)												
Dallinor	- 독립증		4 Donation 5 Other (Specify)  KNESSETH ISRAEL ANSHE KOLK 8/28/98  DUNDALK  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  SOL LEVINSON & BROS.,												
	Physician /Medical Examiner		23a. Part1. Enter tha diseese, or complic shock, or haart failura. List only on Immediata Causa (Final disease or condition rasulting in death)	cations that caused to a cause on each line		h. Do not en	ter the mod	a of dyin		OWN R	OAD raspiretory e	PIKESVI		MD 21208 Approximete Interval Batween Onsat and Death	
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	Attending Ph ar death. ector: Aftar thi by tha funeral	atlon	27. Mannar of Death  **ANatural 5   Panding 2   Accident invastigation	28a. Data of Injury (Month, Day	Year)	28b. Tima o Injury	M 2	28c. Injur Wor 1 □	yat k? Yas 2 □ N		d. Dascribe	how injury occur	red		
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			Dennis Chute M.D.		1	11 Pen	n Str	eet,	Balt	more	, Mar	yland 21	LZUI		

Registrar

1 1998

SEP

DHMH 16 Rev 6/95

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### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth Month Day Year 1998

5:25 PM

Birthplace (State or Foreign Country)

White

10d Inside City Limits

Approximete Intervel Between Onset end Deeth

29d. Date signed (Month, Dey, Yeer)

1 X Yes 2 ☐ No

1. Decedent's Name (First, Middle, Last) **Physician** John William Simpson Sr. 30 August /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3711 Belair Rd N/A Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year **Funeral** Months Deys 1X M 2□ F 83 Director 206-03-2516 June 15 1915 Usuel Residence of Decedent the Merylend 10a Stete 10b County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Director MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3711 Belair Rd USA 21213 Funerai death 12. Wes Decadent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Meritel Status Black White etc. filed within 72 hours efter 1 2 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Boilermaker 8 Beth - Steel permit. Pages 1 end 2 should be file.
Depertment of Heelth end Mental Hyg.
Important: If Item 27 Is merked other any Injury or other traumest.
DDCs. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) William Herbert Simpson Suzanna Long 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) / daughter Nancy Haag 3711 Belair Rd Baltimore, MD 21213 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete Sept 3 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel from State Middle River, Holly Hill Memorial 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23a. Pert1. Enter the dise rile, or complications that caused the dear shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel conver disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest physician end the buriel-tran Due to (or es e consequença of): Box 68760 Due to (or es e consequenca of): 80

esn for ed by the e signed by t d be detech peed hes **Dege 2** 

certificate be exec of Vital Records, P.O. certificate Physician: funeral director. this Division

þ Completed Be 0

Physician/Medicai Certification:

e Hospital of Attending Ph n 24 hours efter deeth e Funeral Director: After th To the I within 2

> State Registrar

edicai

(Check only one)

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Yeer)

Villa Jr.,

T.

SEP

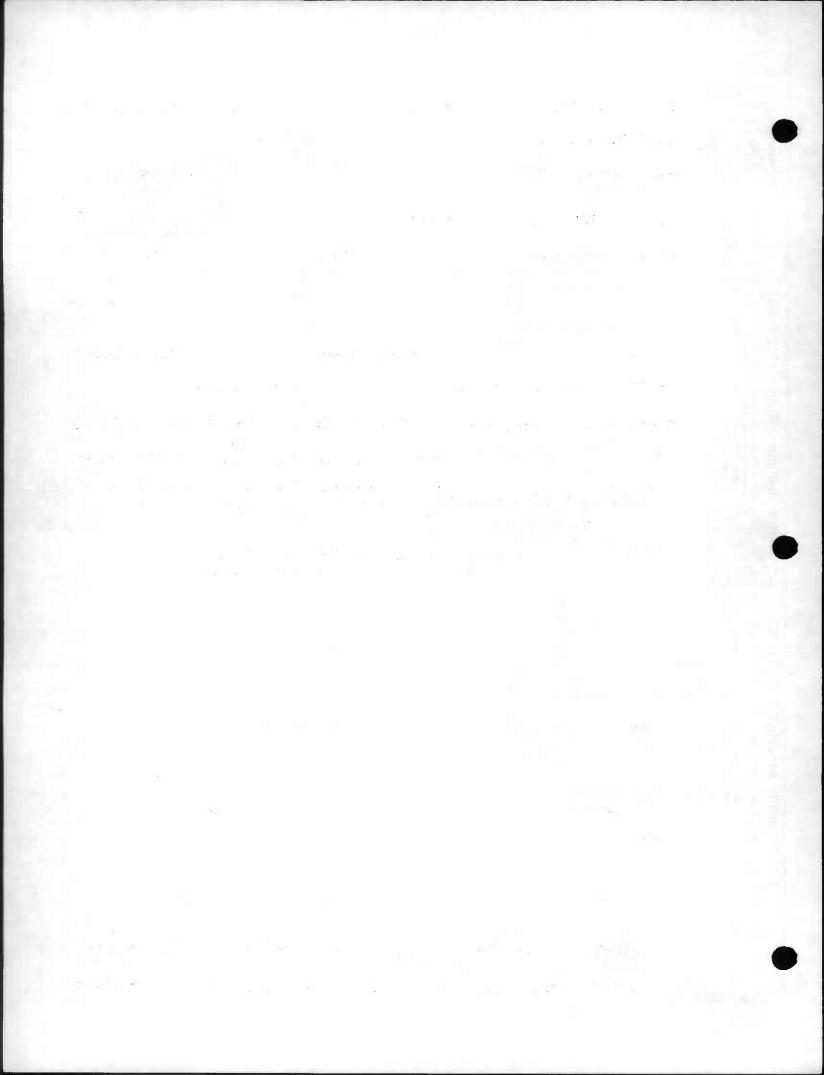
23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 THO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated.

29c. License number

30. Name and eddress of person who completed cause of deeth (tem 23a) (Type, Print) Towson, MD 21204 120 Sister Pierre Dr.

M.D. 32. Registrer's Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#29c per DVR G763 9/1/98 EW 2. Data of Deeth 1. Decedant's Nama (First, Middla, Last) **Physician** AUGUST 26 8:26 am ovise /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Nama (If not institution, giva straat and number) **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE NIA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Date of Birth (Month, Day, Year) 5- 27-3 Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1□ M 20 F 212-36-3202 67 Yrs. MD **Director** Usual Rasidence of Dacedant permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show sny injury or other traumatic event, if a Modical Examinal must be notified at once. 10a, Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits MD Battimore 1 des 2 □ No Director 10a. Street end Number 10f. Zip Coda 10g. Citizan of What Country? Linwood Ave 21205 U.S. A. 801 Funerai Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, atc. 12. Was Decedant Ever in U.S. Armed Forcas? 11, Maritel Stetus 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Specify: Black 1 Yas 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grade complated) AT Home Elamantary/Secondary (0-12) Collega (1-4or 5+) Domestic 10th grade 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be Voung George Scott mary 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 21224 Ave, Batton MD 17 N. Luzerne Scott Hazel 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Catonsville, MD Con 4 Donation 5 Other (Specify) 21. Signatura of Funaral Sarvice Licansee 22. Nama and Addrass of Facility 1101 E. North tue CHET F. H March 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batwaan Onsat and Death **Physician** Immediata Cause (Final disaasa or condition resulting in daath) /Medical Ventricular One week Examiner Due to (or as e consequance of): Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disaasa or injury Dua to (or as e consequence of): that initiated evants rasulting in daath) Last Dua to (or es e consaguance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown failure þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed Dinbetes mellities has s cartificata ha 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Wes casa refarred to medical axaminer? Be 26. Placa of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Aftar 5 Pending invastigation 1 Natural Euneral Director: Af bletaly filled in by tha function 1 ☐ Yas 2 ☐ No 2 Accidant 3 □ Suicida 6 Could not ba 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 4 Homicida 29a. Cartifier Medicai 1 Certifying Physician: To tha bast of my knowledga, death occurred at tha time, date and piece, and due to tha causa(s) and mannar es stated. To the Hosp within 24 hor To the Fune completaly fi 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68766

31. Data filad Month, Day, Yaar)

29b. Signature end titla of cartifiar

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Kinchen,

SEP

State Registrar

DHMH t6 Rev 6/95

29c. License number

Johns Hookins Huspital,

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32. Registrar's Signature

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Typa, Print)

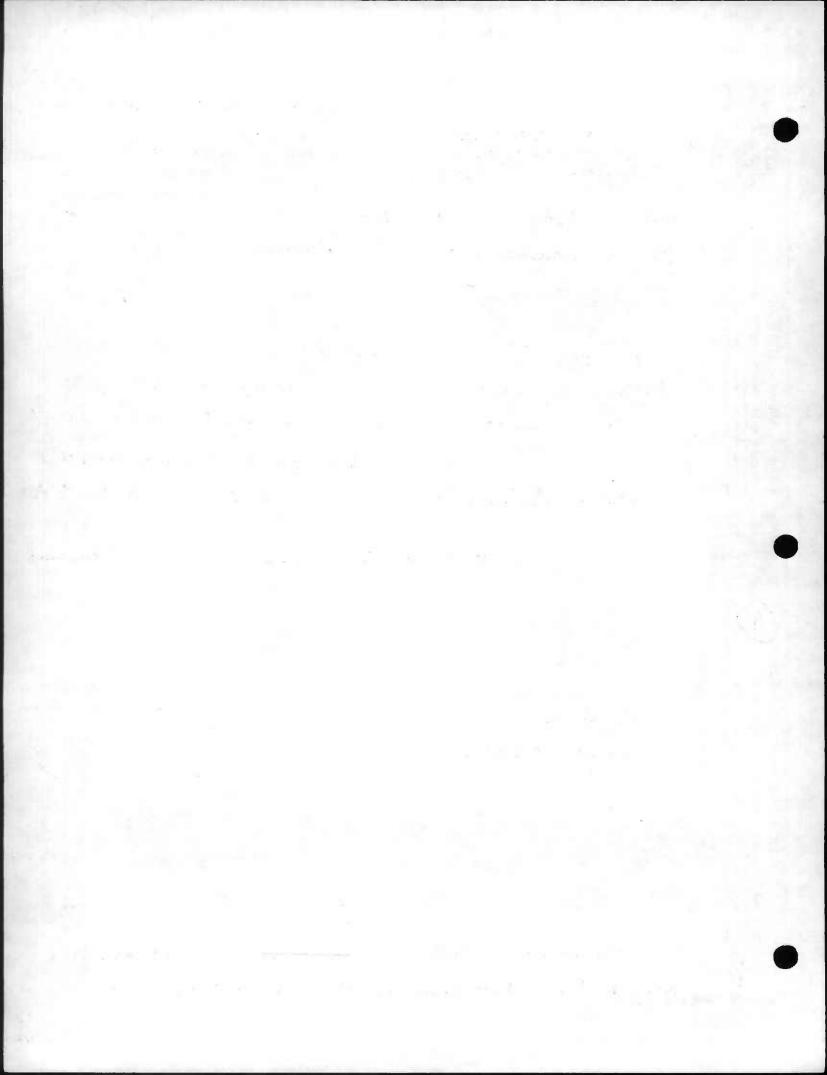
1 1998

29d. Date signed (Month, Day, Year)

August 26,

P10807 000

650 North wolfe, Bultimore, Maryland



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert E. Stevens 10:00 a.m 28 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY BALTIMORIE SHOCK TRAUMA CENTER H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 1 - 1 5 - 1 9 2 2 9. Birthplace (State or Foreign WEST VIRGINIA 5. Social Security Number 6. Sex., 1☐M 2☐ F 7. Age (In yrs. last birthday) **Funeral** 234-30-1761 76 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10e Stete 10d. Inside City Limits MD ANNE ARUNDEL BROOKLYN PARK 1 Yes ZNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 199 CRESWELL ROAD 21225 U.S.A. Funeral 12. Was Decedent Ever in U,S. Agned Forces? 1⁄El Yes 2 □ No If Yes, Give Year or Dates:1942-45 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11 Maritei Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify:WHITE þ 3∆ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BATHROOM FIXTURES Elementary/Secondary (0-12) Coilege (1-4or 5+) AMERICAN STANDARD 17. Fether's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) UNKNOWN REBEKA MAE REED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Name/Relationship (Type, Print) THOMAS RICHARD STEVENS/ SON 8444 BAY DRIVE, PASADENA MD, 21122 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State GLEN HAVEN MEMORIAL PARK 9/1/98 GLEN BURNIE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Bervica Licensee STAGIETON FUNERAL HOME P.A. Skar 1 SECOND AVE. GLEN BURNIE MD 21061 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Multiple organ failure
Due to (or as a consequence of): Examiner perforated diverticulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last progressive preumonia, lung Sailure Physician/Medical progressive polymyositis Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown lupus erythematous, 1 Yes 2 No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? throm so cy to penia , Gastritis à GIbleed. hypothyroidism 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1⊠ Yes 2 No 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident NUNE 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Net if Item 27 Is marked other than "natural", or Items 23a or 28a-f show this if Item 27 is marked other than "natural", or Items 23a or 28a-f show iny or other traumatic event, in Medical Evant ner man be notified as iny or other traumatic event, in Medical Evant ner man be notified as

Baltimore, Maryland 21215-0020

24 hours efter death.

To the To the I

29b. Signature end title of certifier

29c. License number

D3055

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

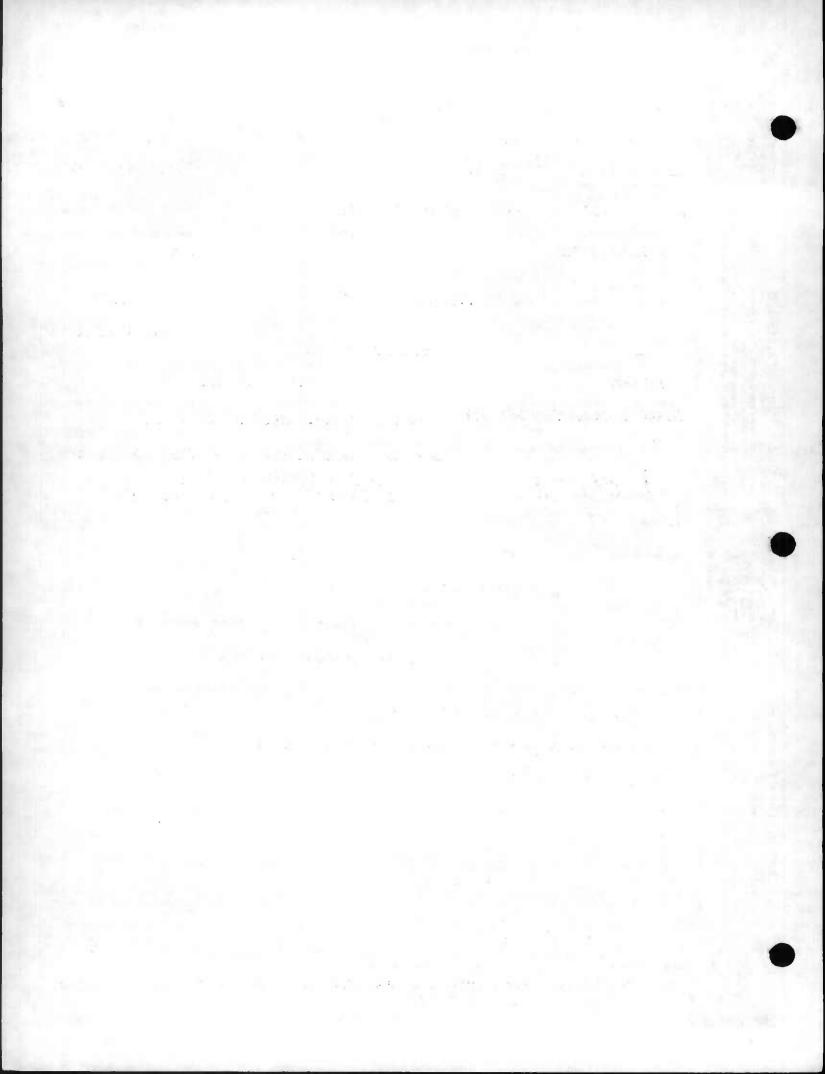
NADER HABASHI, M.D., UNIVERSITY HOSPITAL, 22 S. GREENE ST., BALTO, MD. 21201

29a. Certifier (Check only one)

32. Registrar's Signature

NONE

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 668 Certificate of Death Item#18 per FH G763 9/1/98 EW 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey **Physician** 5 98 4c. County of Deeth HAZEL /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) Examiner BON SE 5. Social Security Number 8. Date of Birth (Month, Dey, Yeer) 10 - 22 - 11 9. Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours Min 220-14-3798 Usual Residence of Decedent Yrs 86 Director with the Marylend permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylen Department of Health end Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examined must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 PYes 2 □ No DALTIMORE NIA Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? LOUDON USA 409 21229 VENUE Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1□ Yes 2□ No 3altimore, Maryland 21215-0020 Specify à 3 ☑ Widowed 4 □ Divorced BLACK Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) OME 8 TH GRADE NIA OMESTIC 17. Father's Name (First, Middle, Last) 18, Mother's Neme (First, Middle, Maiden Sumeme) Be STRAUGHN WARREN Arzie Clark 19a. Informent's Nema/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTO BARBARA 409 MO AUGHIEL LOUDON GRISSOM 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 8-31-98 GARRISON TOREST 4 ☐ Donetion 5 ☐ Other (Specify) Mius. MINIGO 21. Signature of Funerel Service Licensee 22. Name end Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. BAUTO. 21229 Approximate interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner INIFARCTION 12 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, the attending physician The law requires that the death certificate be 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I been signed by the a should be datached 2 No 1 Yes 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? Be Completed has 1 ☐ Yes 2 X No 1 Yes certificate or Attending Physician: 24 hours after death,

Funeral Director: After this certific letely filled in by the funeral director, 1 ☐ Yes No 27. Manner of Deeth Other: 4 Nursing Home STI DOA Certification: To 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of Nate of Injury Month, Day Year) Work? 5 Pending investigation Naturel 1 Yes 2 1 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier Medicai completely (Check only one) within 2 To the 29b. Signature end title of conti 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1998

32. Registrer's Signature

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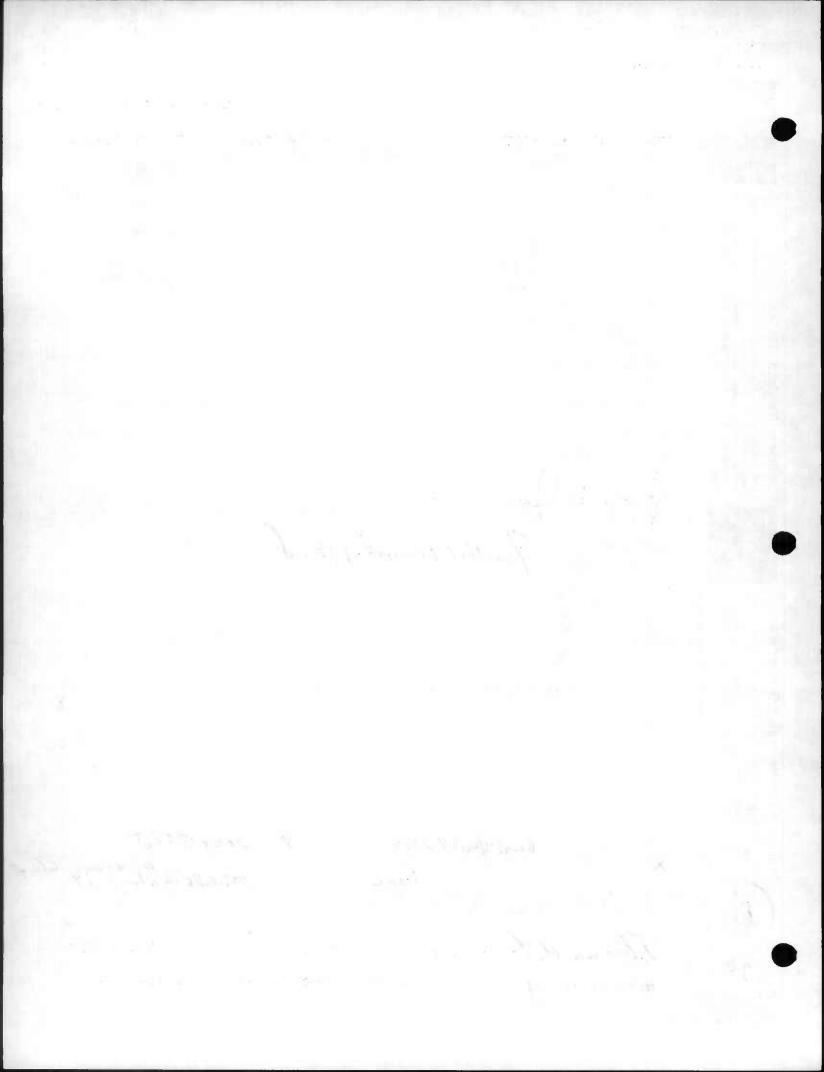
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State of Maryland / Department of Health and Mental Hygiene 9 8 9 6 6 9 9

111 Penn Street, Baltimore, Maryland 21201

Deposition Principles   Deposition   Depos		JOHN W.	T	HOMPSON				Cer	tificate o	f Death			Reg. No.	lives.	2000
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Doc to (or as a consequence of):    Physician   Physi		with with	<u></u>			Court									
Doc to (or as a consequence of):    Physician   Physi		sath	era		3 3	12. Was Decedent	Ever in U,S.	13. W			gin? (Spe	ecify Yes or No			cen Indian,
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Doc to (or as a consequence of):    Physician   Physi	2	othe vent	3e C	17. Father's Name	(First, Middle, Last)					18. Mothe	er's Name	e (First, Middle,	Maiden Suman	ne)	
Doc to (or as a consequence of):    Physician   Physi		Menta Menta rrked rrked	0	John Wil	liam Tho	mpson, Sr				Lid	ldie	Gilcr	ist		
Doc to (or as a consequence of):    Physician   Physi	6	and and as me						19b. Mailin	Address (Stre	et and Numbe	er or Run	al Route Numb	er, City or Town	State, Zij	Code)
Physician   Phys	,	and a alith n 27		Joyce L.	Thompson	- Wife		12601	Kings	ate Co	urt				
21. Senature of Scheral Service Luctifies  22. Name and Address of Facility  March F / H West  4300 Wabash Avenue Baltimore, Md 21215  Approximate	5	of Ha				Removal from State						Dete	20c. Location	City or T	own, State
Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Physician / Medical Examiner  Due to (or as a consequence of):  Due to (or as a cons		Pag mant: i					Mt L	.awn C	emetery	1	18	-31-98	Sharon	Hill	, Pa
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Physician Medical Examiner    Part   Consequence of the part   Consequ				23a. Part Enter	the disease, or compart failure. List only	cations that caused the cause on each li	d the death.	Do not ente	r the mode of d	lying, such es	cardiac	or respiratory a	rrest,		Approximate
Due to (or as a consequence of):    Sequentially list conditions, cause (piece of or as a consequence of):		Physician			,	0	, ,		0	,	1			1	Onset and Death
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State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Vear **Physician** Tsaousis Petros August 31,1998 1:29 AM /Medical 4b. City, Town, or Location of Daath 4e Facility Neme (If not institution, giva streat end number) 4c. County of Death Examiner Edgemere Baltimore 2123 Lodge Forest Drive 5. Sociel Security Number If Undar 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys Hours 1⊠M 2□ F 144-48-7952 61 Yrs. Director Jan. 1,1937 Greece Usuel Residence of Decedent the Marylend 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Hygiene. Vither than "naturel", or items 23s or 28s-f show ent, the Medical Examiner must be notified at 1 ☐ Yes 2 € No Director Edgemere Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? Pages 1 and 2 should be filed within 72 hours efter death with sent of Health and Mentel Hygiene. 21219 United States 2123 Lodge Forest Drive Funerai 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Never Merried 25 Married 1 Yas TV No Specify: Specify. White PY 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 Years Painter Painting 7 is marked other traumatic event, 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be Zoi Kouka Dimitrios Tsaousis 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Wife 19a. Informant's Name/Relationship (Type, Print) Health a Mrs. Pamagiota Tsaousis 2123 Lodge Forest Drive Edgemere, Maryland 21219 item 2. Baltimore. 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Deta 1 Burial 2 Cremetion 3 Removal from State = 6 permit. Page Department of Important: if any Injury or once. St. Konstantninos Cem. 4 ☐ Donation 5 ☐ Othe ((Specify)) 9/4/1998 Krete, Greece 21. Signature of Hunerel Service Licens 22. Name end Addrass of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Cerrix Approximete Intarval Between Onset end Death 23e. Pert1. Enter the diseese, or complications that caused the shock, or haart failura. List only one cause on each line Do not enter the mode of dying, such as cardiac or raspiretory errest, **Physician** /Medical Immediata Causa (Finel PU diseese or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Dua to (or as a consequence of): The law requires that the death certificate be and P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. the bed signed by the 10 108 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wera autopsy findings aveilable prior to completion of cause of daeth? should I Completed 24e. Wes en eutopsy performad? is certificate has t director, page 2 s 1 ☐ Yas 1□Yes 2□No Hospital or Attending Physician: 25. Wes case referred medical Be 26. Piece of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 28c. Injury et Work? 27. Menner of Deeth 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred After 5 Pending Investigation Injury s after dee. 1 Watural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide • Funeral Di 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred et tha tima, dete end pleca, end due to tha causa(s) and mannar as stetad.

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pleted cause of death (Item 23a) (Type, Print)

32. Registrer's Signatura

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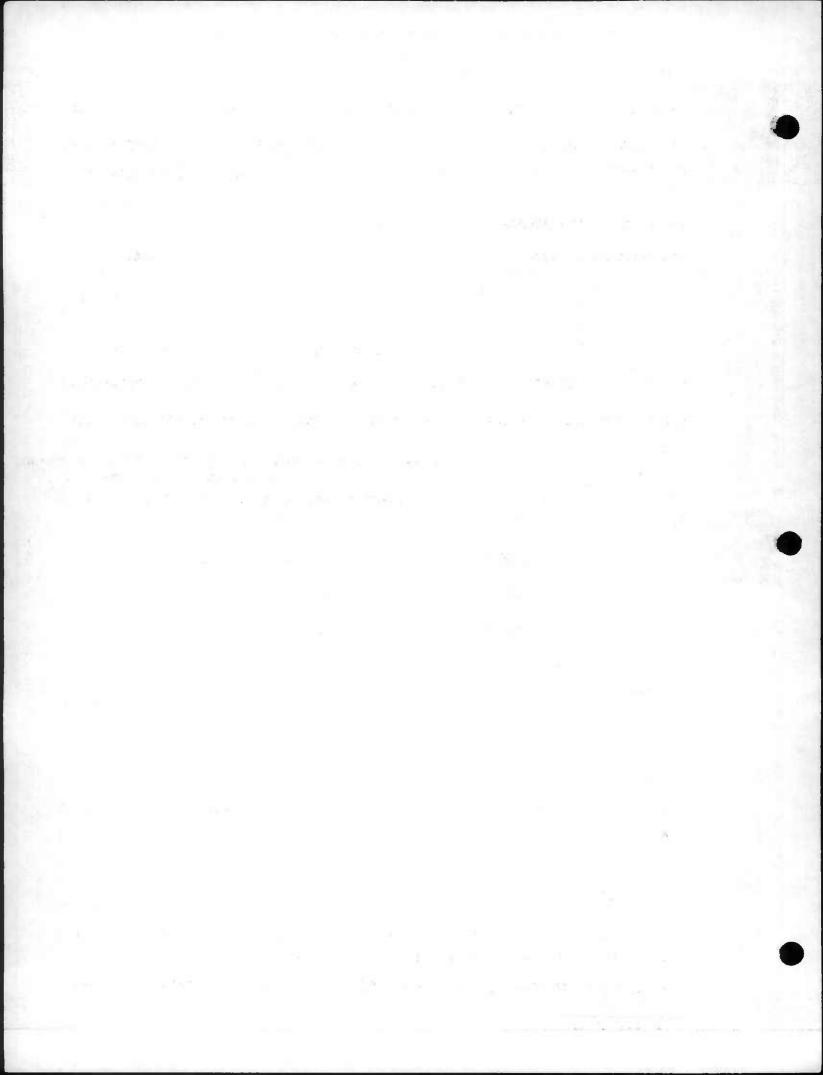
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М,		5. Social Security Number 216-68-9045	6.	Sex 1XIM 2□F	7. Age (In yrs.		Months De		Min. (Month, D.	rth ay, Year)	Cou	plece (State or I intry)
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth **Physician** Month Theresa Castagnera August 30, 1998 Valt 4:25 pm /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Genesis ElderCare-Heritage Center Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Month, Day, Yea 7-29-1911 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 1 F Deys 87 215-16-9268 Yrs. Director Atlanta, Georgia Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location r than "natural", or itams 23a or 28a-f show the Wedgal Examiner must be notified at 10d. Inside City Limits MD n/a Baltimore Director 1 Yes 2 No 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 211 S. Clinton Street 21224 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: if flem 27 is marked other than "natural!", or framany injury or other traumette. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White p 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker 8th 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Bearzotti Irmalena Caretti 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Valt 211 S. Clinton St., Baltimore, Md. 21224 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ■ Buriel 2 ■ Cremation 3 □ Ramoval from State 9/4/98 Baltimore, Maryland Oaklawn Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signetura of Funeral Service Licansee 22. Name end Address of Fecility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one cause on each line. **Physician** ARDIO PULMONARY ARREST

Due to (or es e consequence of): /Medical Immediate Ceuse (Final diseese or condition resulting in death) Examiner EUMONIA

Due to (or es e consequence of) the buriel-transit pue Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in deeth) Last MALNUTRI Box 68760. physician Pe Physician/Medical 98 ettending Por ed by the e P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records. py been sig 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? Completed 24e. Was an autopsy performed? page 2 1 Yes 2 16 1 Yes 2 No Division of Vital 25. Was cese referred to medical 26. Plece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 1) Naturel 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Hor: 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 500 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) To With To 29b. Signature and title of certifian 29c. License number 29d. Data signed (Month, Day, Year) Place Battomae MD

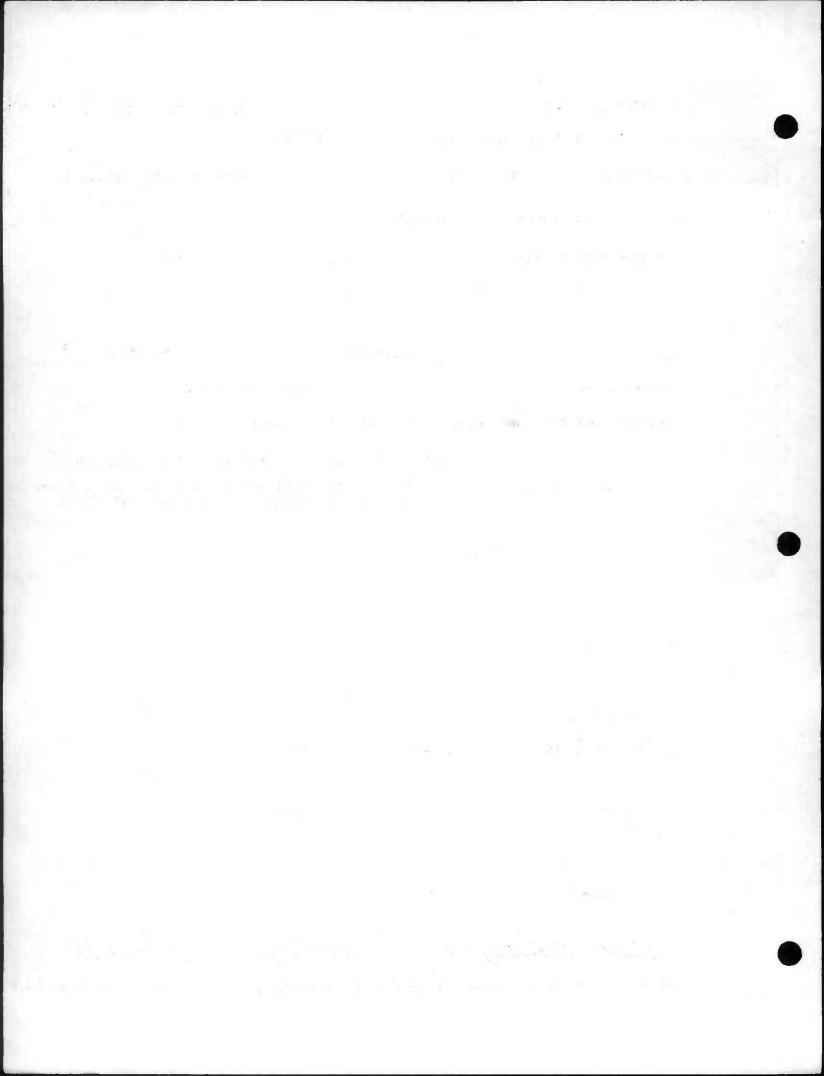
2. Registrer's Signeture

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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ther this certificate has been signed by the structurophysician and the bundal transit to be defined by the bundal transit of the bu	edical Certification: To Be Completed by Physician/Medical	Immediate Ceuse (I disease or condition resulting in death)  Sequentially list con if eny, leeding to im cause. Enter Under Cause (Disease or ithet intitled events resulting in death) L  Part II. Other signification of the control	ed to medical livest 6 Could determ	b  c  d  lone contrib  rifla f  al Hos  ing ligation I not be mined  ing Physicial Examiner.	pital: 1   Inpat 28a. Dete of In (Month, D) 28e. Plece of It building, e	Due to (or  Due to	EP/Outpetient 28b. Time of Injury wiedge, death	uence of):  uence of):  uence of):  uence of):  t 3 □ DOA □ 28c. If  M □ 1  occurred et the estigetion, in m  29c. Lice	26. FOther: 4Enjury et Nork?	Plece of Deeth Varing Hor  Union 12	23b. Did 1	tobecco use  Yes 2 No s en eutopsy ormed?  Yes 2 No cone)  Idence 6 C how injury occ (Street and Num, State)  ceuse(s) end date end plec	contribute 3 P  24b.  Other (Specurred  menner ese, end due	Approximete Intervel Between Onset end Deat 3



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** MYRA WARREN 4b. City, Town, or Location of Death /Medical 4c. County of Death 4a. Facility Name (If not institution, give street end number) Examiner BALtimore MARY and
5. Social Security Number 7. Age (In yrs. lest birthday) It! GENERAL If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth Month, Day, NOV 24, 9. Birthplace (Stete or Foreign **Funeral** 1□M 2√2F Months Days 96 TENNESSEE 214-20-1517 Director Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r is marked other than "natural", or items 23s or 26s-f show traumetic event, the Medical Examiner must be notified as N/A BALTIMORE CITY 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3311 TOONE STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas XX No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Race - Amarican Indian, Black, White, etc. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER permit. Pages 1 and 2 aboutd be tited w. Department of Health and Mental Hygiers important; if them 27 is marked other tha any fujury or other tea. CROSS & BLACKWELL UNKN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be CALVIN WARREN FLORENCE PARKS 2 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA FITZPATRICK/NIECE 525 N. CURLEY STREET BALTIMORE, MARYLAND 21205 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, cremetery or other place)
BALTIMORE WASHINGTON CREMATORY LAUREL, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVENUE BALTIMORE, MARYLAND 21224 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrest, mount failure. List only one cause on each line. **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Examiner ongestive Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting In death) Last Due to (or as a consequence of): respiratory istress Physician/Medical Division of Vital Records, P.O. Box 6876 Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings avaitable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed peed hes certificete 1 Yas 207 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certific 25. Was cese referred to medicat Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 tnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) funeral 27. Manger of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accidant 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signatura and title of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Yeer) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

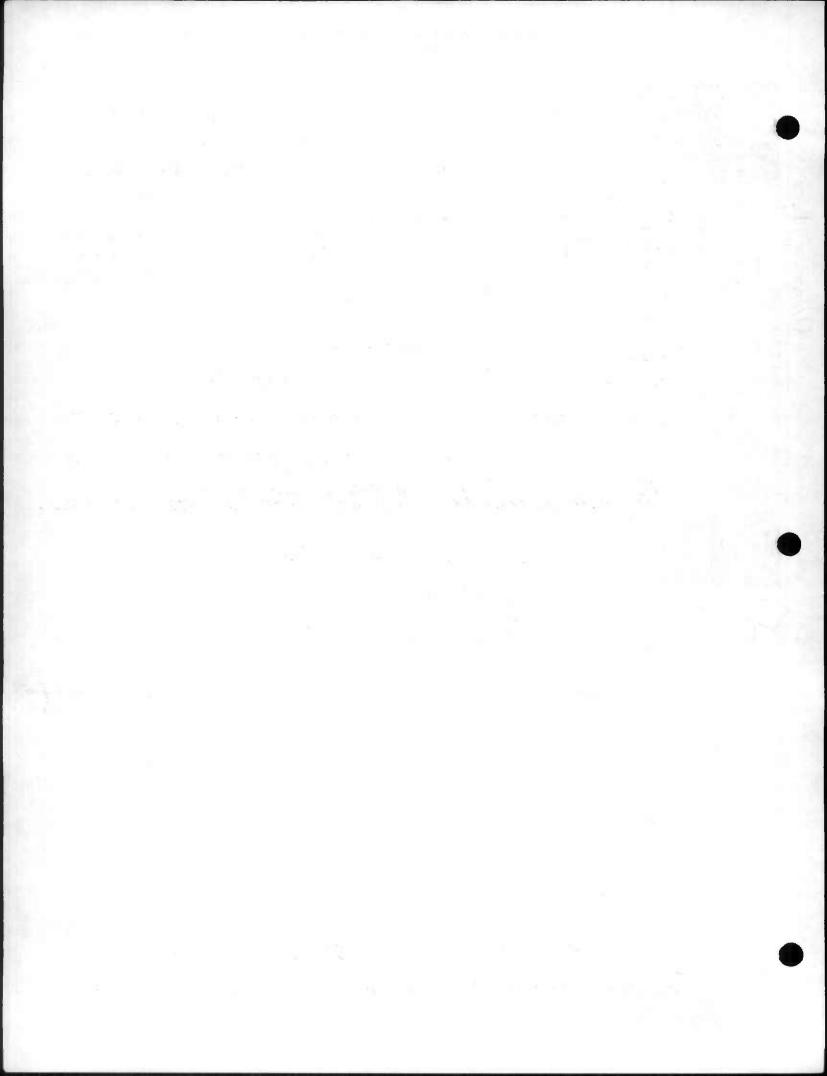
3e. Registrar's Signature

lorad

31. Date filed (Month, Day, Year) SEP 0 1 1998

Go MARYland GENERAL HOSpitAL

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Day Month **Physician** Yeer Hatson Richard August 30,1998 5 30 pm /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** XXM 2 F Deys Hours 53 Yrs. Director 218-46-2630 10/20/1944 MD. Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28a-f show the Medical Example must be notified at 1 X Yes 2 □ No Director MD. N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3600 HUDSON STREET 21224 U.S.A. Funerai death 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2√☐ No Specify: Completed by Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 YEARS FACTORY WORKER 7 is marked other traumatic event, COMPUTER INDUSTRY Baltimore, Maryland 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maide . Peges 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth jury or other traumatic even Be MORGAN WILHELMINA WILLE 2 19e. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PAUL H. WATSON 3600 HUDSON ST. BALTIMORE, MD. 21224 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date Weurial 2 Cremetion 3 Removel from State permit. Pege Depertment of Important: If any Injury or once. SACRED HEART OF JESUS 9/2/98 4 Donation 5 Dother (Specify) BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility & SON, INC.

BALTIMORE, MD. 21221

Approximate Intervel Between Onset end Death CHARLES S. ZEILER & SON, INC. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on aach line. **Physician** /Medical Immediate Cause (Final immediale diseesa or condition resulting in daath) e. Respiratory obstruction Examiner Due to (or es e consequance of): ukusus. Examiner and neck tumor Sequentielly list conditions, if eny, laading to immediate causa. Enter Underlying Cause (Diseese or Injury that Initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68769, Physician/Medical The law requires that the death certificate Due to (or as e consequança of): signed by the eld to be deteched for Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 3⊠ Probably 4 □ Unknown 1 Yes 2 No Anomia Records. þ 24b. Were eutopsy findings evelleble prior to completion of cause of daeth? pege 2 should Completed 24a. Wes en eutopsy performed? severe weight loss certificate 1 ☐ Yes 2 1 No of Vital Physician: director. Be 25. Wes case rafarred to medical 28. Piece of Daath (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Othar (Specify) 2 1 Yes 2 No // S efter dea... 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending 5 Pending invastigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Stata) 4 Homicide within 24 hours To the Funeral C completely filled Hospital 15 Certifying Physicien: To the best of my knowledge, daath occurred et the time, dete end place, and due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et tha tima, data and place, end due to the ceuse(s) end mennar statad. Medicai (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) August 31, 1998 30. Nema and address of person who completed causa of daeth (Item 23e) (Type, Print) JHBHC Dr. Younes 4940 Eastern Balt, MD 21224 31. Dete filed (Month, Dey, Year)

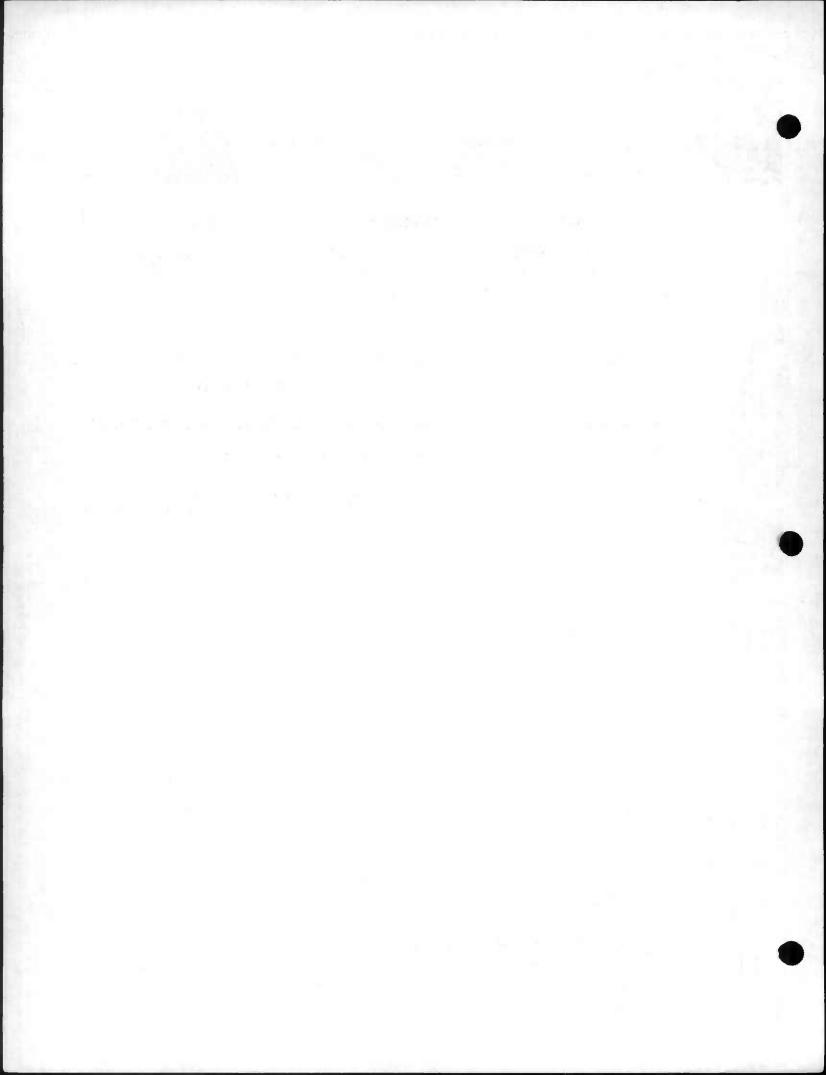
32. Registrer's Signature

SEP 0 1 1998

**DHMH 16 Rev 6/95** 

State

Registrar



#### Piease Type or Print in Biack Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 26689 Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Ware rnice August /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location Deeth Examiner 12 aa ve. MOre Sa If Undar 24 Hrs If Under 1 Yaar 5 Social Security Number 6. Sex 8. Date of Birth 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 20-22-Months Deys Min 220-22-6396 Usual Residence of Decedent 1□ M 2 F Yrs. 10n State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 □ No Director Maryland more 10e. Stre et and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 212 a 6 Funeral . Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Ttro American Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementagy/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Ware 19a. Informant's Name/Relationship (Type, Print) (dayghter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) salto. Md. 21215 a 10701 20b. Place of Disposition (Neme of cargetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Dother (Specify) 22. Name end Address of Feoility JOSEPH L. KUSS ZZZZ W. North Home S -uneral Joseph Balto. Md. 21216 Ave. fions that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory errast, Approximete Interval Between Onset end Death e, or complied List only one Immediate Cause (Final disease or condition resulting in death) a consequence of) Due to (or a Physician/Medical Examin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ited events in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes ď 24b. Were eutopsy findings aveilable prior to completion of cause of death? Certification: To Be Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 1 Yas 2 No 25. Was case referred to medical 26. Piece of Deeth (Check only one) 2DENO Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 3 DOA Residence 6 Other (Specify) of of the 28a. Date of Injury (Month, Day Year) 28b. Time of 28d Describe how injury occurred 5 Pending investigation 2 No

Division of Vital Records, P.O. # After or Attending

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mi Department of Haelih and Mentel Hyglens. Important: if item 27 is marked other than "naturel", or items 23s or 25s 1, any Injury or other traumatic event, the Medical Examiner must be motified and and any injury or other traumatic event, the Medical Examiner must be motified.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

adical

**Ø**∏ Ancident

3 Suicide

29a. Certifier

29b. Signal

4 | Homicide

after death Director: To the Hospital within 24 hours a To the Funeral C

> State Registrar

6 ☐ Could not be

32. Régistrar's Signature

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

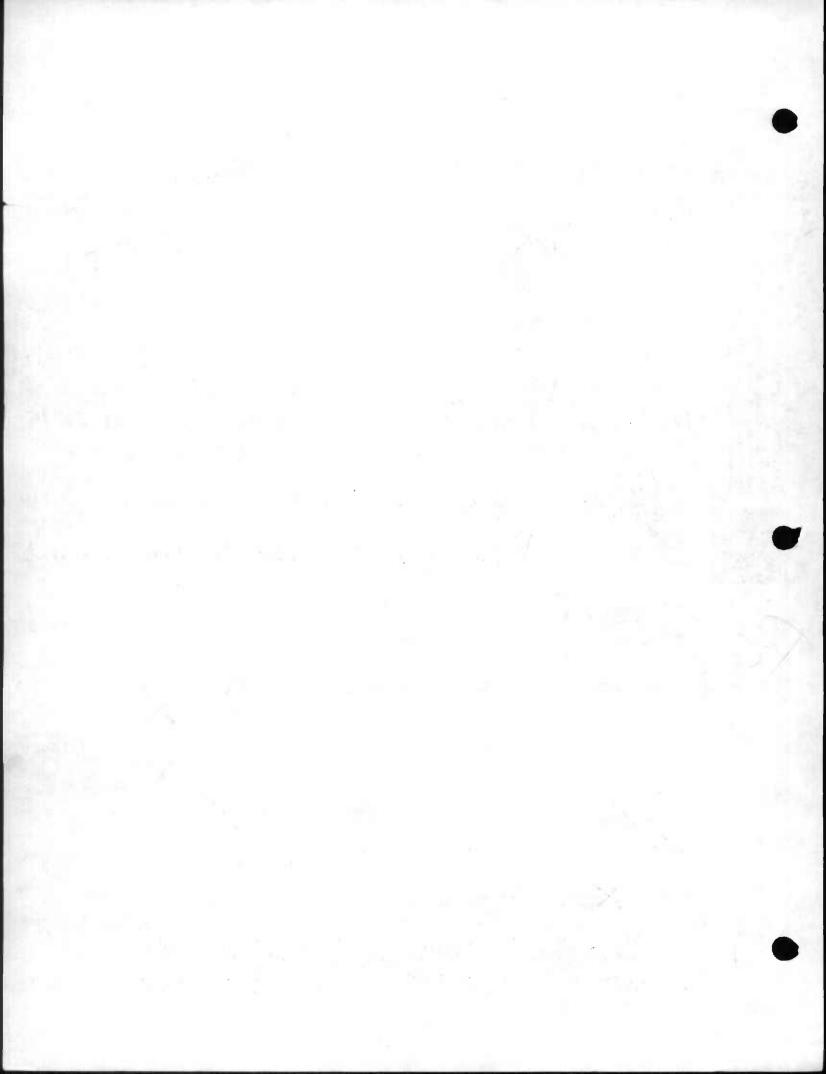
29c. License number

1 Yes

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

MOTE

29d. Dete signed (Month, Dey, Year)



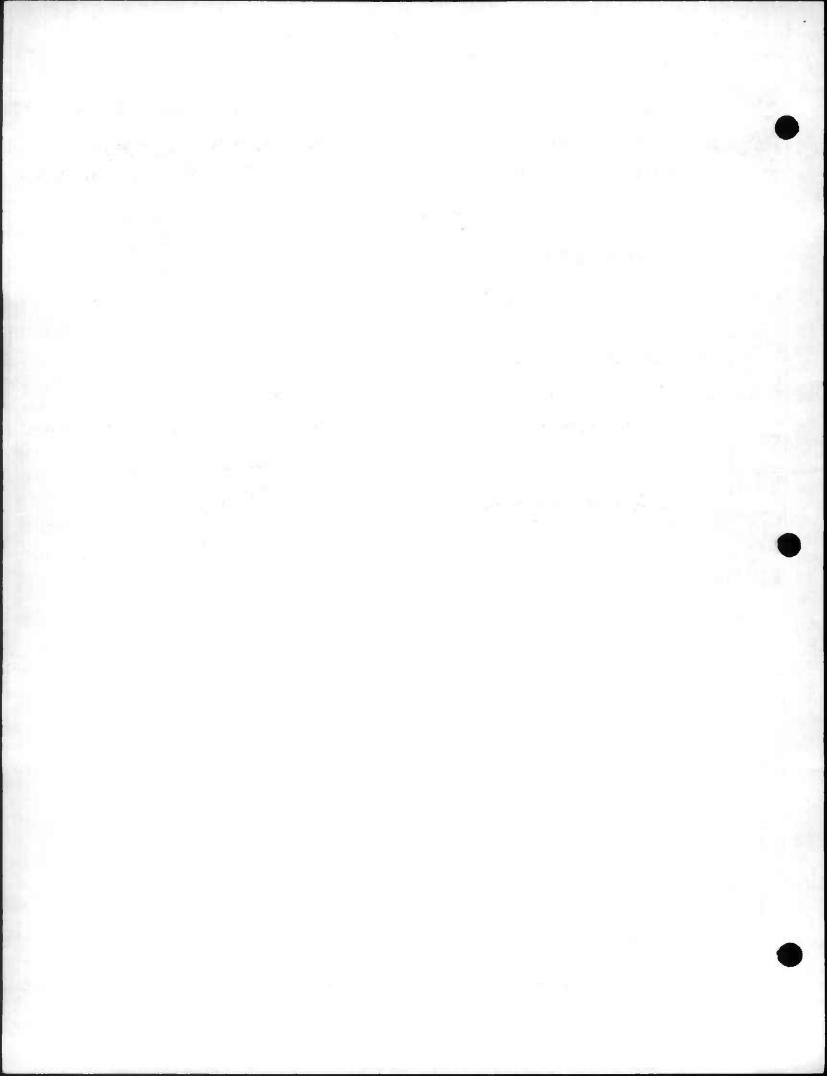
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#16b per FH G763 9/1/98 EW 1. Decedent's Name (First, Middle, Last) 2. Date of Death PASQUALINA **Physician** Month WOEHLKE 08:00AT AUGUST 1998 /Medical 4a. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore, Maryland Baltimore City | H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 1, 1919 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M aX F 79 Yrs. 220-09-2318 Director Baltimore, Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show trsumatic event, the Medical Examiner must be notified at Baltimore City 1X Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ŏ "natural", or Items 23a 7111 Old Harford Road 21234 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes ※☐ No If Yas, Give Year or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene. Important: If them 27 is marked other than "natural", or heany Injury or other trauments. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowad 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Homemaker 12th Grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Angelo DeSantis Rose Pabula 19e. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Copperwood Court-Millersville, Maryland 21108 of Disposition (Name of Date 20c. Location - City or Town, State David B. Woehlke - Son 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 8/25/1998 Baltimore, Maryland 21. Signature of Funaral Service Licensaa 22. Name and Address of Facility
Lassahn Funeral Home, Inc. 7401 Belair Road - Baltimore, Maryland 21236 23a. Part Enter the disaasa, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, enock, or heart fellure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) SEPSIS 3 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown STROKE signed b Records, þ Be Completed ATRIAL FIBRILLATION 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) P-12556 AJAY CHAWLA M.D. AUGUST 22, 1998 30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) CHAWLA THE GOOD SAMPRITON HOSPITAL OF MORYLAND , MD. 31. Dete filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

SEP 0



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Yeer 16:45 AUDREY WOODARD 4b. City, Town, or Location of Death 1998 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Undar 24 Hrs. 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Deys Hours 1 M 2 F 64 Yrs MD 218-28-6628 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2612 WEGWORTH LANE 21230 U.S.A. 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: Specify AFR. AMERICAN 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working lifts. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE CITY Elementary/Secondary (0-12) Callege (1-4or 5+) **SCHOOLS** TEACHER'S ASST. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) ELMER TURNER MILDRED TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) RENEE WOODARD-MARTIN (DAUGHTER) 2612 WEGWORTH LANE BALTIMORE MD 21230 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20s. Method of Disposition 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE V.A. CEM. AUG. 27,98 CROWNSVILLE WALKER 22. Name end Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 23a. Part1. Enter the disease, or complice shock or heart feilure. List only one Approximata Intervel Between Onset end Death who is that caused the leath. Do not antar tha mode of dying, such es cardiac or respiratory errest cause on eech line. Immediete Cause (Finel Septicemia One Month disease or condition resulting in deeth) Due to (or es e consequence of): Repa hronic-Unknown Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of) Dronory Artery Viscast Due to (or es e consequence of): Right Ventricle ne month Thrombus in 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2 No 1 Yas 2HNo 26. Piece of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

· /Medical

Examiner

Director

Funeral

by

Completed

Be

**Funeral** 

Director

than "natural", or hams 23a or 28a-f a the Medical Examiner must be notified

Hygiene, other than

permit. Pages 1 and 2 should be fis Department of Health and Mantial Hy Important: if them 27 is marked oth any fulury or other traumatic event Apric.

Baltimore, Maryland 21215-0020

Examiner

Physician/Medicai

p

Completed

Be

10

Certification:

Ses signed by the a page 2 has

this certificate funeral After death. after death Director:

Medical

Records, P.O. Box 68760. or Attending Hospital 24 hours within 2 To the the th

Woodard, Hudray

State Registrar

25. Was case referred to medical axaminer? 1 Yas 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Impatiant 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Suicide 4 HomicIde 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. (Check only one)

2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

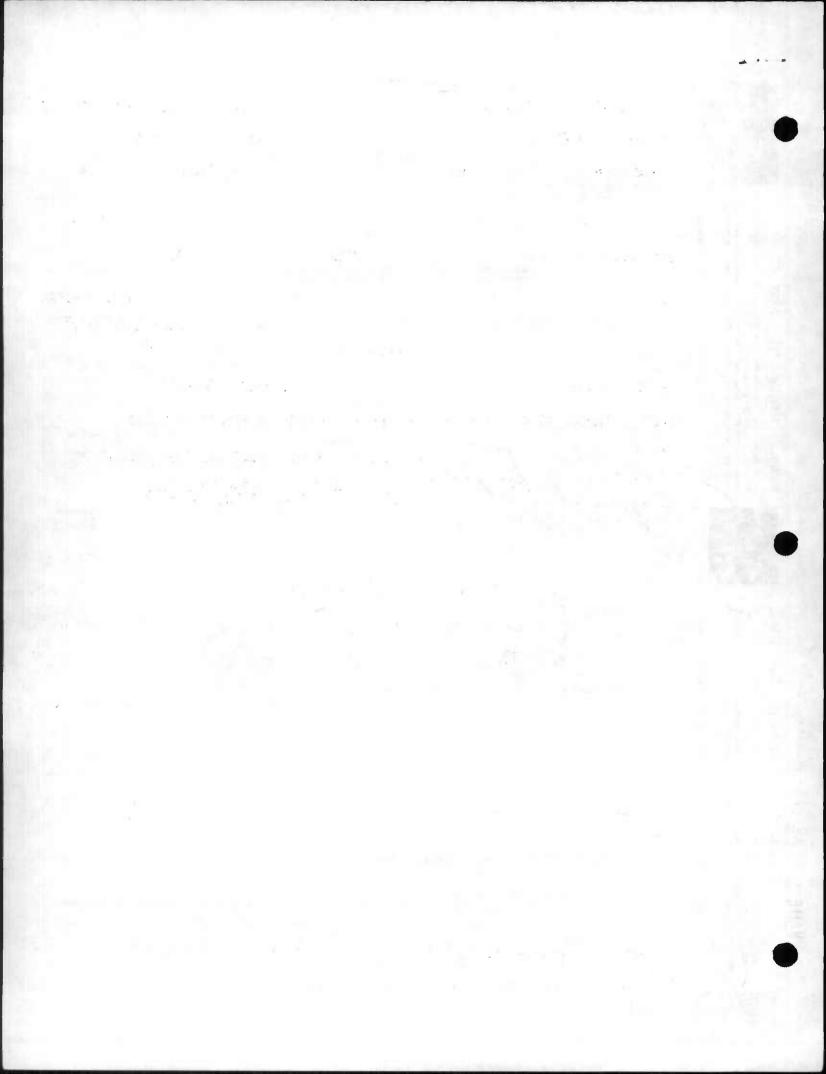
29b. Signatura and titla of certifier

John

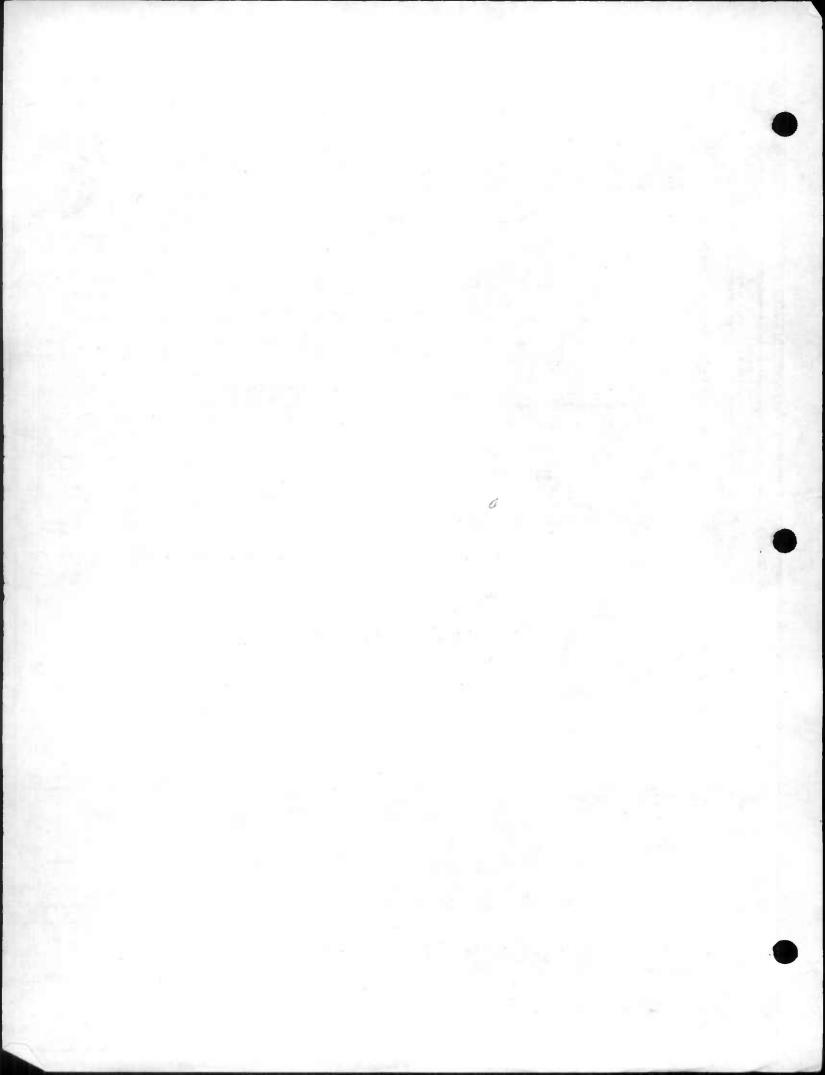
30. Nemedend eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Baltimore 900 Avenue MD Caton 00000 31. Date filed (Monith, Day, Year) SEP 1 1998 32. Registrar's Signeture

**DHMH 16 Rev 6/95** 



	1. Decedent's N	ame (First, Middle, Las	st)					2. Dete of D		Veer	3. Time of Deal
cian Iical	Mary	y	F.			Yarboui	r	August	29, 1	Year 1998	6:00
iner	4a Facility Nem	e (If not institution, give	e street and number	r)			4b. City, Town,	or Location of Dea	th 4c. Count	ty of Death	
		Main St.				WILL A V	Dunda			Balti	
l r	5. Social Securit	4	ex 7. A □ M 2 XXX		(ast birthday)	If Under 1 Year Months Deys		Ain. (Month, D	irth ay, Year)	9. Birthpi Coun	lace (State or For
	Usual Residence	4-2603   '			60 TIS.			March	27,19	338	MD
	10a. State	10b. County		10c. Cit	y, Town or Loc	cation				10	0d. Inside City Lin
	MD	Ba1	timore		Dui	nda1k					1 □ Yes 🗷
200	10e. Street and I	Number			0.000	10f. Zip Code			10g. Citizen of	Whal Coun	iry?
	537 Ma	ain St.				212	222		USA		
	11. Marital Statu	S	12. Was Deceden	Ever in U	,S. 13. V	Vas Decedent of Yes, specify Cui	Hispanic Origin ban, Mexican, P	(Specify Yes or Nuerto Rican, etc.)	o- 14. Ra	ace - Americack, White,	
	The state of the s	arried 2 Merried	1 ☐ Yes 2X			☐ Yes <b>2KDK</b> id			1.000	ity: B1	
	3 DI Widowe	d 4 Divorced	Year or Dates	:							
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	Rando	Name/Relationship (7			19b. Maitin	a Address (Stree		r Rural Route Numi			Code)
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۱	20a. Method of D			20b. F	Plece of Dispos	sition (Neme of	V 1.0	Date	20c. Location		
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Medical Examiner	Immediate Caus	se (Finel lition th) conditions, b immediate nderlying or injury shis	e. Me; b. Lu c. Core	Due to (co	Lation es e consequence	uence of):					Intervet Between
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Certification: To Be Completed by Physician/Medical	Immediate Caus disease or cond resulting in deat Sequentially list if any, leading to cause. Enter to Cause (Disease that initiated everesulting in deat Part II. Other signal P	conditions, o immediate nderlying or injury shits h) Last   inferred to medical properties of investigation	e. Me; b. Lu c. C. Core d. Intributing to death  Hospitel: 1 Inpat  28a. Date of In (Month, D)  28e. Place of In building, e	Due to (or Due to (or	or es e consequente de la consequente del consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente del consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la consequente de la conseque	uence of):  uence of):  uence of):  uence of):  defrying cause g  28c. Inju W M 10  28c. Inju W Opet, fectory, office	26. Place of ther: 4 Nursir ury at ork?	23b. Dio  24a. We perful  24b. Describe	tobacco use conversely to the san autopsy formed?  Yes 2 No one) Sidence 6 One how injury occur.  (Street and Number, Stete)	24b. We ave colored their (Specific urred)	o the cause of debebly 4 United t
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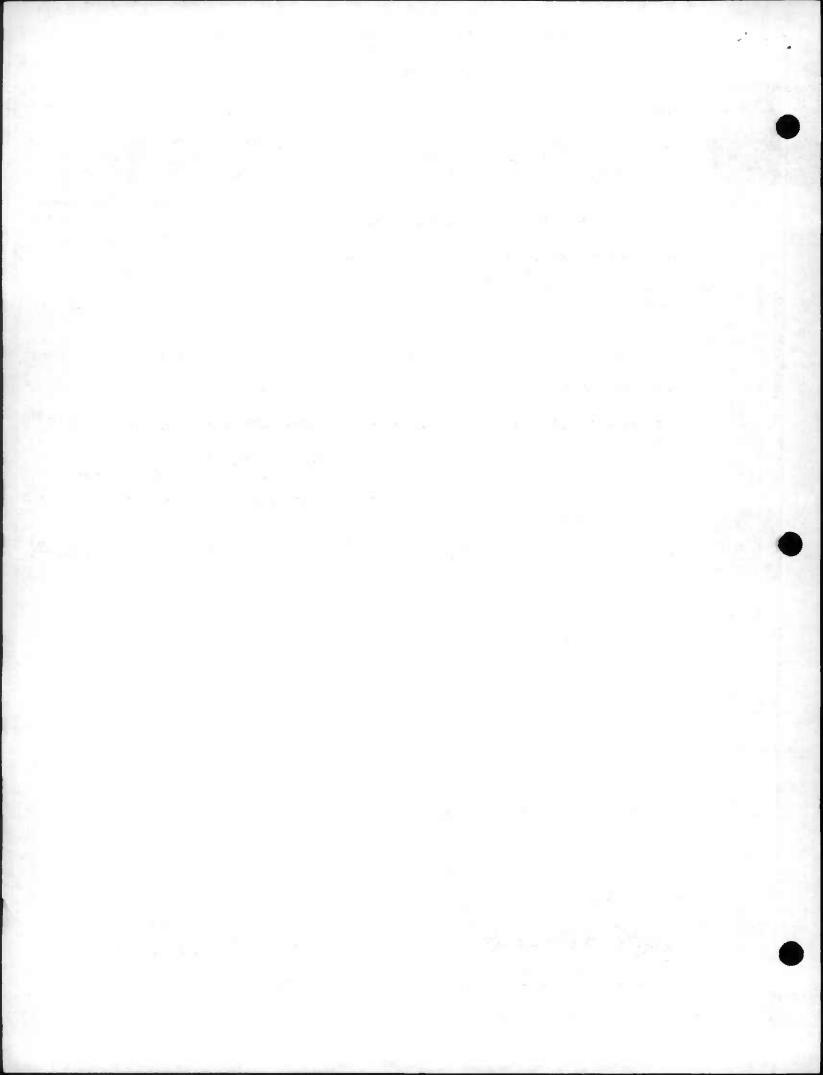


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month 12,1998 Phyllis J. Averinos Aug 06:34pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1□ M 2 🔀 F Devs Hours Yrs. Director 579-28-8181 80 Jan Canada Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 10820 Georgia Ave, #109 items 23a 20902 IISA Funeral lied within 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 ☐ No þ Specify 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be liled within 7. Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, in Media once. Elementary/Secondery (0-12) College (1-4or 5+) 8th Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Emmanuel Glezos Sophia Katsouros 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, Cify or Town, Stete, Zip Code) Dorothy Glezos/Sister 10820 Georgia Ave, #109, Silver Spring, MD 20902 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery Aug 17 Suitland, MD 22. Name end Address of Fecility Hines-Rinaldi Funeral Home 21. Signeture of Funeral Service Licenses 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. Dist only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** Ischemic Cardiomyopathy /Medical Immediate Cause (Final Month diseese or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e consequence of): physicien s the burial Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 3 No 3 Probably 4 Unknown by 24a. Was en eutopsy performed? 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed hes 1 🗆 Yes certificete 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was cese referred to medicel exeminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1☐ Yes 2 No this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Neturel death. 1 🗆 Yes 2 Accident Director: / 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide the Hospital within 24 hours of To the Funeral I Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted. Medical 29e. Certifier 29c. License number 29b. Signature and alle of card 10 To 29d. Dete signed (Month, Dey, Year) Aug.13,1998 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Jeffrey Indrisano Md. 10801 Lockwood Dr. Suite 280 Silver Spring Md 20901 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State AUG 1 9 1998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	5. Social Security	The second second	6. Sex		Age (In yrs		1	If Under Months		If Under 24 Hours	Min.	Date of Bir (Month, De	th ly, Year)	9. 1	Birthpled	ce (Stete or F
Francis of Health and Mental Hygiera.  Fant: If Item 27 is marked other than "natural, or items 23a or 23as above than "natural, or items 27a to recise than "natural, or items 27a to other transmite event, the Medical Examiner must be notified at 10.  To Be Completed by Funeral Director	214-90-6		1 L N	1 2X F	21	Υ	rs.				FI	EB. 13	, 1977	7 WA	SHI	GTON,
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1	17. Fether's Neme		Last)							18. Mother's			, Maiden Su	rmeme)		
	Robert	Austin								Margo	o Jol	nnson				
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2	20e. Method of Dis	•				Place of cemetery	Disposit	ition (Nen	me of	ca)	1	Date	20c. Local	tion - City	or Town	n, Stete
П		☐ Cremetion		novel from Stat	Mou					matory	8/1	7/98	Alexa	ndria	а,	VA
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	20a. Method of Disposition  1 Burial 2 Cremetion  4 Donation 5 Other (S	pecify)/	Stete	emetery, c	position (Neme remetory or oth	er <i>pl</i> ed			ug 14, 1998	20c. Location		own, Stete	
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Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

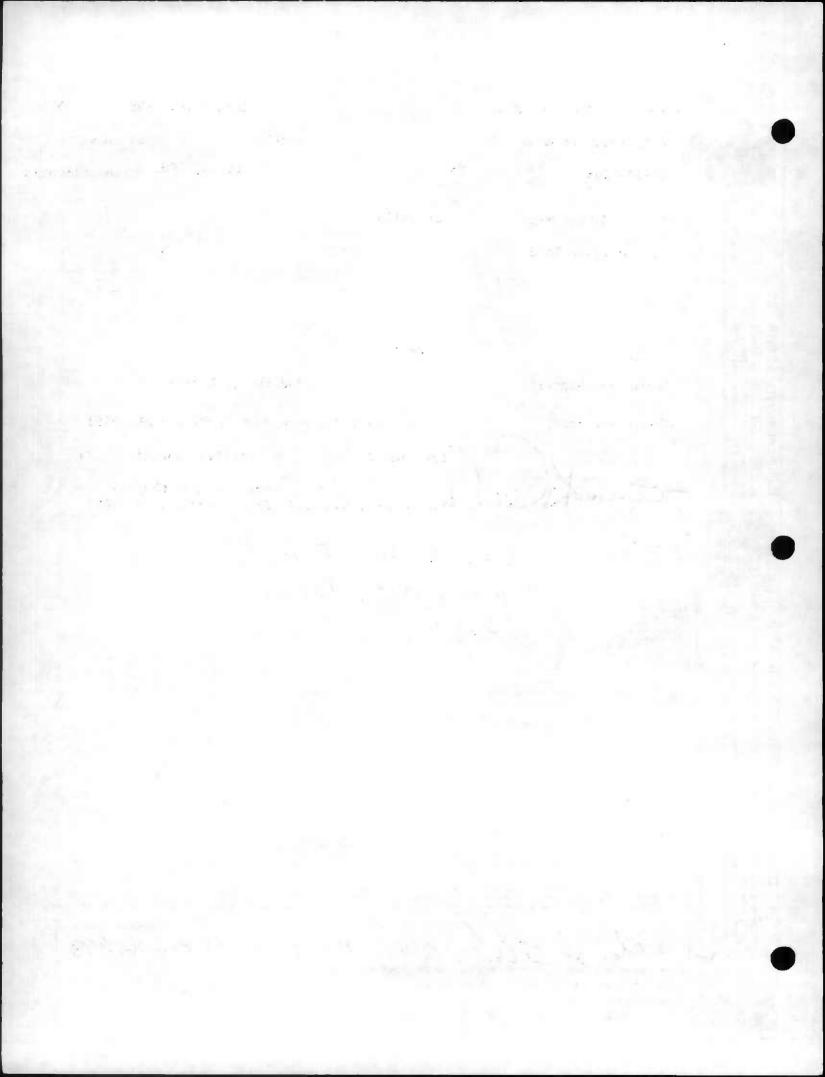
of the first of the context of the c n +45 50 Table 10 TERRITOR OF STATE OF GROWING CONTRACTOR

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Dey **Physician** August 14, 1998 9:00pm Bernard Abraham /Medical 4a Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 6111 Montrose Road #408 Rockville Montgomery If Undar 24 Hrs. 8. Data of Birth OCL 1902 5 Social Security Number 7. Aga (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Deys 11 M 2□ F Hours 95 109-14-3566 Czechoslovskia Director Usuel Residence of Deceden 10a State 10c. City. Town or Location 10d Inside City Limits 10b. County 1 Yes ≥ No Director MD Rockville Montgomery notifie 10f. Zip Code 10g. Citizen of What Country? 10e, Street end Number "natural", or items 23s or officel Examiner must be USA 20852 6111 Montrose Road 南 Funer 12. Wes Decedant Evar in U,S. Armad Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien Black, White, atc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Upholsterer OWN 10 18. Mother's Name (First, Middle, Maiden Sumama) 17 Fether's Neme (First Middle Last) Pages 1 and 2 should be fit ment of Health and Mental Hants I it sent 27 is marked oth lury or other traumatic even 88 Judith (unknown) Herman Abrahamovitz 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Abraham/wife 6111 Montrose ROad #408 Rockville MD 20852 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 8/17/98 Rochellen, NJ Riverside Cemetry 4 ☐ Donetion 5 ☐ Other (Spe 21. Signeture of Funeral Sept 22. Name and Address of Fecility Danzansky Goldberg Memorial Chapels 1170 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Herri disaase or condition resulting in deeth) Examine Examiner physician end the burial-transit iew requires that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760 p5:1 Physician/Medical Due to (or es e consequenca of) 80 usa 0 signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings availabla prior to completion of cause of deeth? 24a. Was an autopsy Completed performad' is certificate has director, page 2 2 No 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 1 Naturel 5 Pending 1 Yes 2 No death. investigation Hospital or Attend 24 hours after death Funeral Director: 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 5 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletaly filled in b 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of cartifier - D-30885 AUG 16, 1998 40 0 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Dete filed (Month, Day, Year) AUG 1 8 1998 State Registrar

Dr. Thomas Goldbaum - 5530 Wisconsin Avenue #515 - Chevy Chase, Maryland 20815 32. Pagistrar's Signature



State of Maryland / Department of Health and Mental Hygiene 3 26697

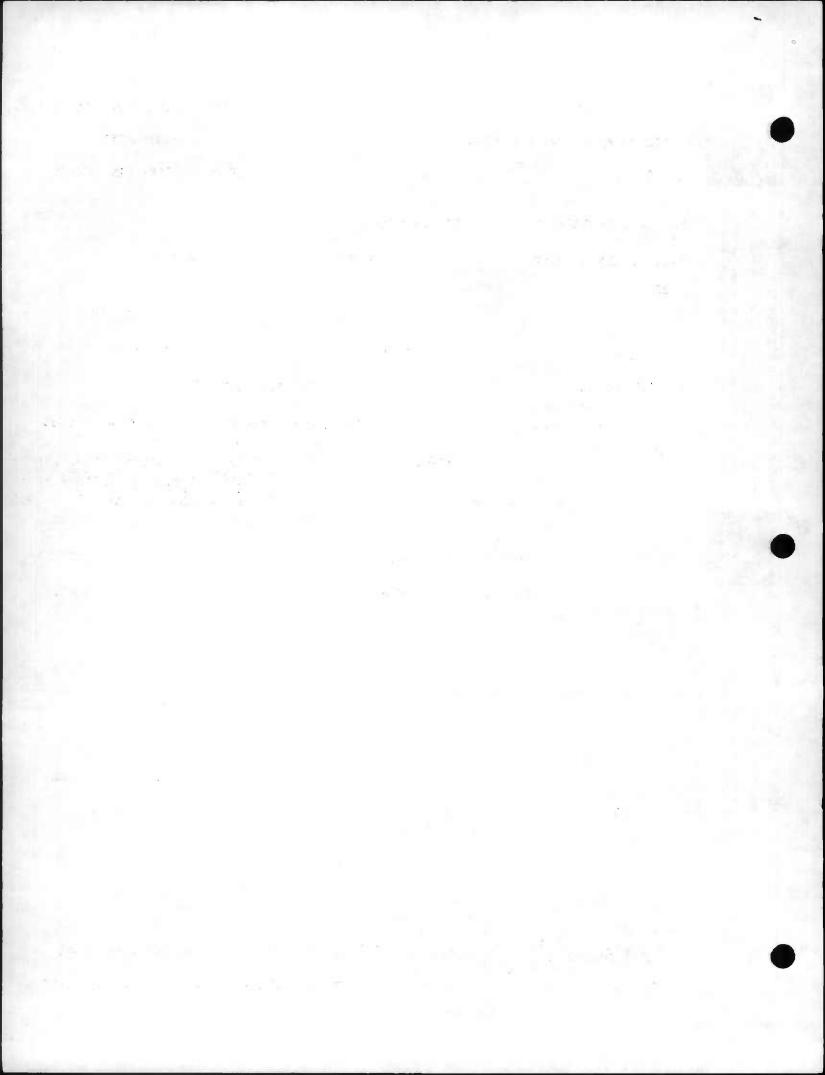
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Examiner	4a Fecility Neme (If not in:	stitution, give	street end nu	mber)	-			4b. City, Town, or	Location of Deeth	4c. County	of Deeth		
	MONTGOMERY G	ENERAL	HOSPI	TAL				OLNEY		MONTGO	MERY		
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tal Hygiene. d other than event, tre Me	17. Fether's Neme (First, A	fiddle, Last)						18. Mother's Ne	me (First, Middle,	Meiden Sumen	ne)		
should be nd Mental marked o matic eve	DEWAYNE BOYE	R						BEVERLY	HARTLEI	N			
and h	19a. Informent's Name/Re	letionship (Ty	rpe, Print)		19b. Maili	ng Addre	ss (Stree	t and Number or R	urel Route Numbe	er, City or Town,	Stete, Zip	Code)	
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pemit. Pege Department of Important: If any injury or phcs.	21. Signeture of Funerel S	ervice Licens	Don	ne 00				ess of FecilityHIN		LDI FUNI HAMPSHII	ERAL RE AV	HOME, ENUE	INC
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)				or es e conse	quence of					14	HOURS	S
asith certificate be executed attending physician and for use as the burial-transit clary/Medical Examiner	Sequentially list conditions if eny, leading to immedie ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest		c		or es e consec	quence of	):					HOUR	)
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certificate has rector, page 2 Be Comp									10	Yes XX No	1[	□ Yes X	X.No
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After thi funaral		Pending investigation	28a. Dete		28b. Time o Injury		28c. Inju			how Injury occur			
tal or Attending P rs efter death. al Director: After t led in by the funara Certification:		Could not be determined	28e. Plece build	of Injury - At h	ome, farm, sti	reet, facto	ry, office		28f. Location ( City or Tox	Street end Num wn, State)	per or Run	el Route Nur	n <i>ber</i> ,
Hospi 14 hou Funer taly fill	(Check only 2 M. one)	dical Exami	ney. On the b			vestigatio	n, in my	ime, dete end plece opinion, death occi		date and place,	and due t	o the ceuse	s)
Within 2 Within 2 Within 2 Within 2 Within 3 Wit	29b. Signeture and title of	certifier /	A/1	Line	1	MD	9c. Licen	se number		29d. Date signe			

State Registrar

RONALD H. USCINSKI, 31. Date filed (Month, Day, Year) AUG 19 1998

PHILIP DRIVE, SUITE 104 OLNEY MARYLAND 20832

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month Day **Physician** WILLIAM JOSEPH BRADFIELD August 1025 AM 10 /Medical 4b. City, Town, or Location a Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner SHADY GROVE ADVENTIST HOSPITAL

Ass //p urs. last birthday) | fl Undar 1 Year ROCKVII.I.F.

If Undar 24 Hrs.
Hours | Min.

8. Data of Birth
(Month, Day, Year) MONTGOMERY Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number **Funeral** Months Days 15 M 2□ F 83 West Virginia August 19, 1914 Director 577-09-3817 Usual Rasidance of Decedan 10c. City, Town or Location 10d. insida City Limits 10a Stata 10b County 1 ☐ Yas 2 ☑ No Maryland Montgomery Bethesda or man "natural", or thems 23s or 28s-f. the Medical Examiner must be notified Directo 96 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 20814 4508 N. Chelsea Lane United States Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 M Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) filed within Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) P.E.P.Co. Substation Operator marked other 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oth any injury or other traumatic even Be William Bradfield Catherine McConnell 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 3 Pavilion Drive, Gaithersburg, Maryland 20878 Elizabeth B. Lennon/Daughter 20b. Place of Disposition (Nama of camatary, cramatory or other place) August 18, 1998 20a. Method of Disposition 20c. Location - City or Town, Stata Rockville. 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Othar (Spacify) Maryland Parklawn Memorial Park 21. Signatura of Funaral Service Licen 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/ thesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Bethesda-Chevy Chase, Inc. M00689 disaasa, or complications that ceused in death. Do not enter the mode of dying, such as cardiac or respiratory arrast, initure. List only one ceuse on each line. **Physician** /Medical Immediata Causa (Final Months disaasa or condition rasulting in daath) Examiner Examiner physician and s the burief-trensit The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immadiate ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): for use es signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to been si Completed 24a. Was an autopsy performed? completion of ceusa of death? page 2 s 28TNo 1 ☐ Yas 2 ☐ No 1 Yas certificate director, Be 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Chack only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 ☐ Yas 2 No Certification: To 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA this 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 Yas 2 No

Division of Vital Records, P.O. Box 68760 or Attending Physician: efter deeth. After this funerel of Funeral Director: stely filled in by the hours Hospital 24

edical To the Fune completely fi To the 2

> State Registrar

2 Accidant

3 Suicida

29a. Certifiar

4 Homlcida

(Check only one)

PRANS.

29b. Signature and title of Ann

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)

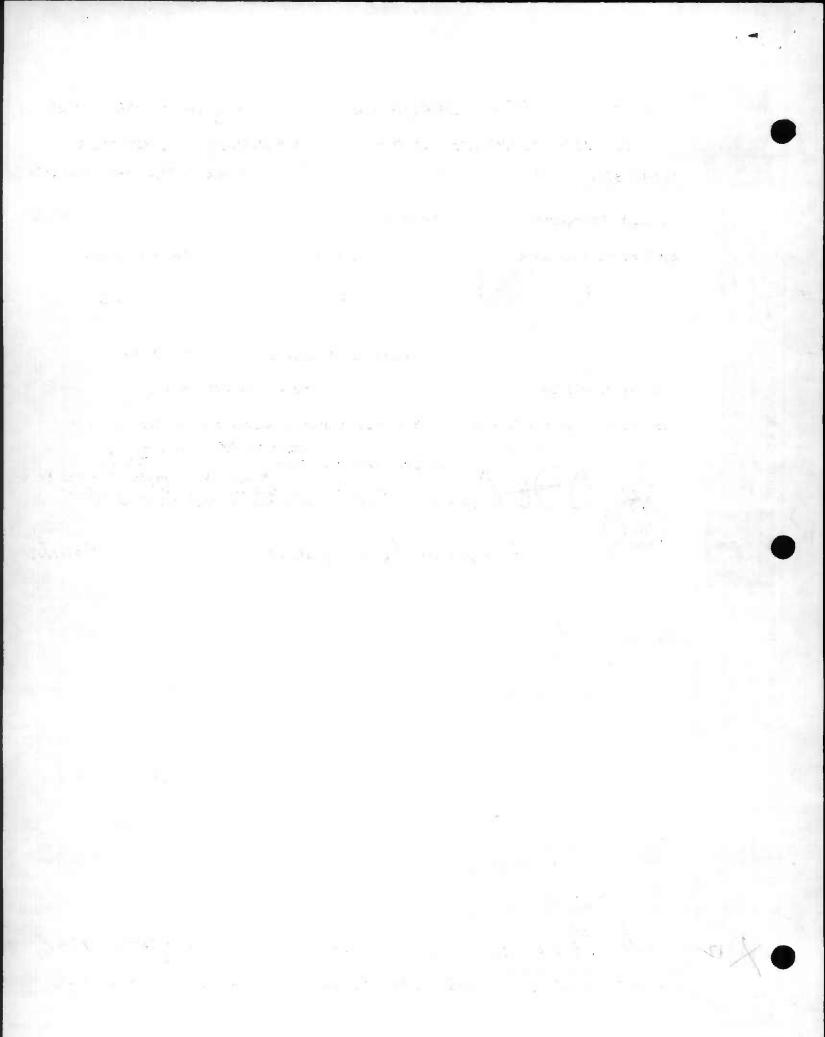
GROVE RD RUCKULLE MO 20850 CHANALES 15245 SHADY

31. Data tiled (Month, Day, Year) AUG 1 8 1998

6 Could not be determined

32. Degistrar's Signatura

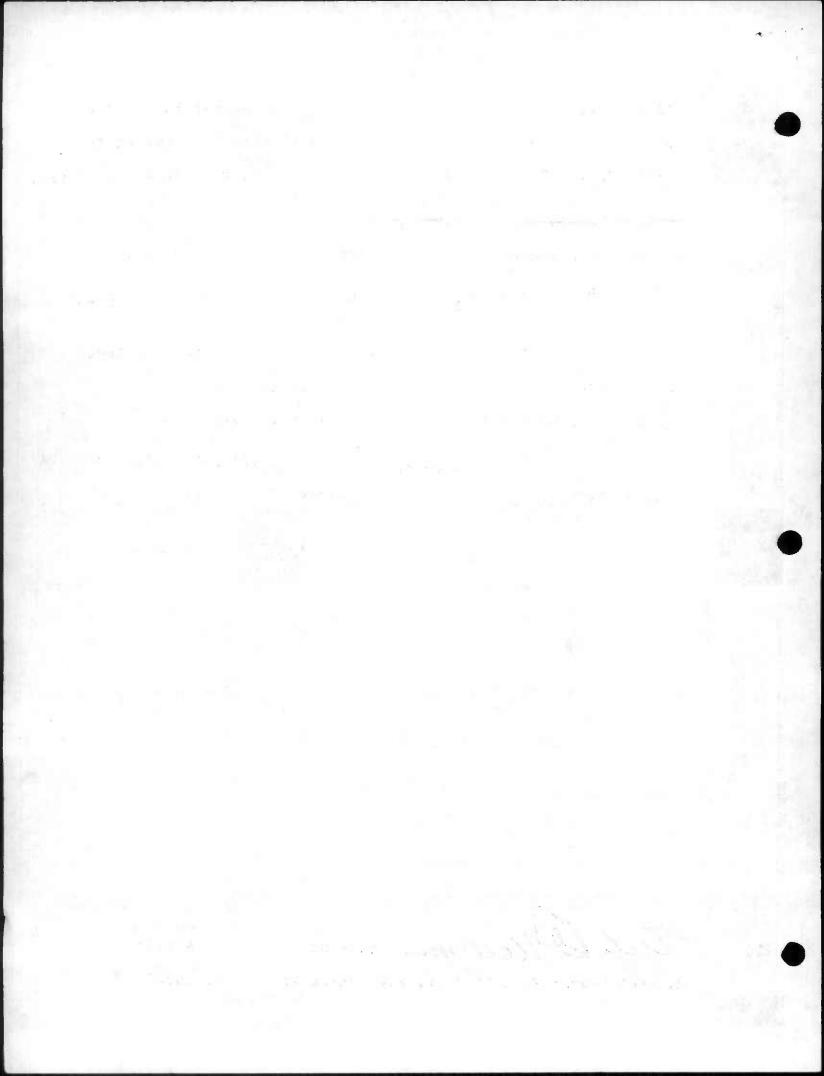
28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

AMEND: #10A, B, C, E, F, PER INFORMANT G763 9-15-98 WR Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Деу 11, 1998 9:50 mm August Albert Brodsky /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Montgomery Bethesda Suburban Hospital If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) Apr. 6, 1925 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 1 1 M 2 □ F Yrs. Director 137-14-9981 73 New Jersey Usual Residence of Decedent FLORIDA 10b. County 10d. Inside City Limits 10c. City, Town or Location BOYNTON BEACH 28a-f show must be notified at Director 1 Yes 2 □ No Maryland Montgomery Chevy Chase with tha 10e Street and Number 55 WOODS LANE 10f. Zip Code 10g. Citizen of Whet Country? 20815 33436 U.S.A. 4550 N. Park Avenue Funeral death Itams 2 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Maritel Status 14. Race - American Indian, traumatic evant, the Medical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours aftar in ant of Health and Mental Hygiena. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: ₩ ₩ ፲ ፲ Baltimore, Maryland 21215-0020 5 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Developer Self-Employed 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be h and Mental F Minnie Baer Louis Brodsky 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 20815 4550 N. Park Ave. Chevy Chase, MD Lois Brodsky/Husband 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition 20c. Locetion - City or Town, Stete HD Burial 2 ☐ Cremation 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) 8/13/98 Falls Church, VA King David Mem. Gdns 21. Signeture of Funerel Service Licenses Ives-Pearson Funeral Home ights that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, ause on each line. 22201 23a. Pert1. Enter the disease, or compticat shock, or heart feilure. List only one Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final years e. Coronary Artery Disease disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner years Hypertension The law requires that the daeth certificate be axecuted Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or injury thet initiated events resulting In deeth) Last buriel-tran and Due to (or as a consequence of): Box 68760 attanding physician Physician/Medical tha Due to (or es e consequence of) P.O. F signed by the at d be dateched for Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Prostate Cancer Division of Vital Records, P cata hes been sig. Completed 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2K No 1 ☐ Yes 2 ☐ No certificata or Attending Physician: Be 25. Was cese referred to medicel 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes \$□ No Affar this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel daath. 1 Yes 2 No 2 Accident Director: A 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homloide To the Hospital
within 24 hours e
To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29e. Certifier Medical NOn the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 8/12/98 50 5496 DC 30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) 2021 K St. N.W. Washington, D.C. Michael Newman, MD 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar

**DHMH 16 Rev 6/95** 



			Cert	illicate 0	f Death			Reg. No.		
1. Decedent's Name (First, Middle, La	ist)						2. Date of Dec		Var-	3. Time of Death
Joseph All	en B	RUCE	=				Month	Dey + 15	Yeer 1998	10:40 ar
e. Fecility Name (If not institution, giv					4b. City, To	wn, or L	ocation of Deeth		ty of Deeth	
Doctors Communi	ty Hospit	al			Lanha			Prin	nce G	eorge's
Social Security Number 6. S	Sex 7. A	ge (In yrs. lest		If Under 1 Yes		24 Hrs. Min.	8. Date of Birt (Month, De)	h y, Yeer)	9. Birth	plece (State or Fore
5/8-40-3399	1⊠M 2□F	65	Yrs.				May 4,	1933		bama
Jsual Residence of Decadent  0a. State 10b. County		10c City T	Fown or Loc	ation						10d Incide Ott 11-
										10d. Inside City Limi 1X Yes 2□N
MD Prince G	eorges	Upp	per Ma	arlboro			1			
0e. Street end Number 9206 Fairhaven A	Want -			10f. Zip Code		7.0		10g. Citizen of		untry?
					2077			T	USA	
1. Marital Status	12. Was Deceden Armed Forces	?	13. W	les Decedent o Yes, specify Co	t Hispenic Ori uben, Mexican	gin? (Sp i, Puerto	pecify Yes or No- p Rican, etc.)		ace - Ameri eck, White	lcan Indien, , etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 x Yes 2 ☐ If Yes, Give	1951 <b>-</b> 5	2 1	□Yes 2⊠N	o Specify:			Spec	ify: [	White
15. Decedent's Ed (Specify only highest gre		1	(Give k	ent's Usual Occ rind of work dor O NOT use reti	e during most	t of work	king	16b. Kind of I	business/lr	naustry
Elementery/Secondery (0-12)	College (1-4or	5+)			, ou)			T7	d D-	iaira
7. Father's Name (First, Middle, Last,	)		Crou	ıpier	18. Mothe	r's Nam	ne (First, Middle,		nd Ra:	ısıng
Walter Bruce									/	
19e. Informent's Neme/Reletionship (	Tune Print		10b Mellin	Address /C-			I. Mout		n Cinic T	in Codo'
Cheryl Bruce	(wife)									
Oa. Method of Disposition	(MTTE)	20h Plen		talrna ition (Neme of	ven AV	inue	, Upper	Maribo 20c. Location		
1 ☑ Burial 2 ☐ Cremation 3 ☐		e cem	etery, cremi	etory or other p		8	3/24/98			
4 □ Donetion 5 □ Other (Specif		Anda	lusia	(Magno	lia) C	emet		Andalus		
21. Signeture of Funeral Servica Licer	See Ct						ancis J			
James F	1 56	W	Si	llver S	oring	אט כ MD	iversity	A RIAG.	west	C
disease or condition	e. 3(	adder						rest,		Approximete Intervel Between Onset end Deeth
Immediete Cause (Final disease or condition resulting in death)	e. 3(a	Due to (or es	s e consequ	ence of):						Intervel Between
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disease or condition resulting in death)  Sequentially list conditions, feny, leading to Immediate ause. Enter Underlying Ceuse (Disease or Injury hat Initieled events	e. <u>3(a</u>	Due to (or es	s e consequ s e consequ	ence of):				1001,		Intervel Between
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DHMH 16 Rev 6/95

Sta Regist

Physic /Medi Exami

Funeral Director

permit. Peges 1 end 2 should be filled within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Medical Examinet must be notified at once.

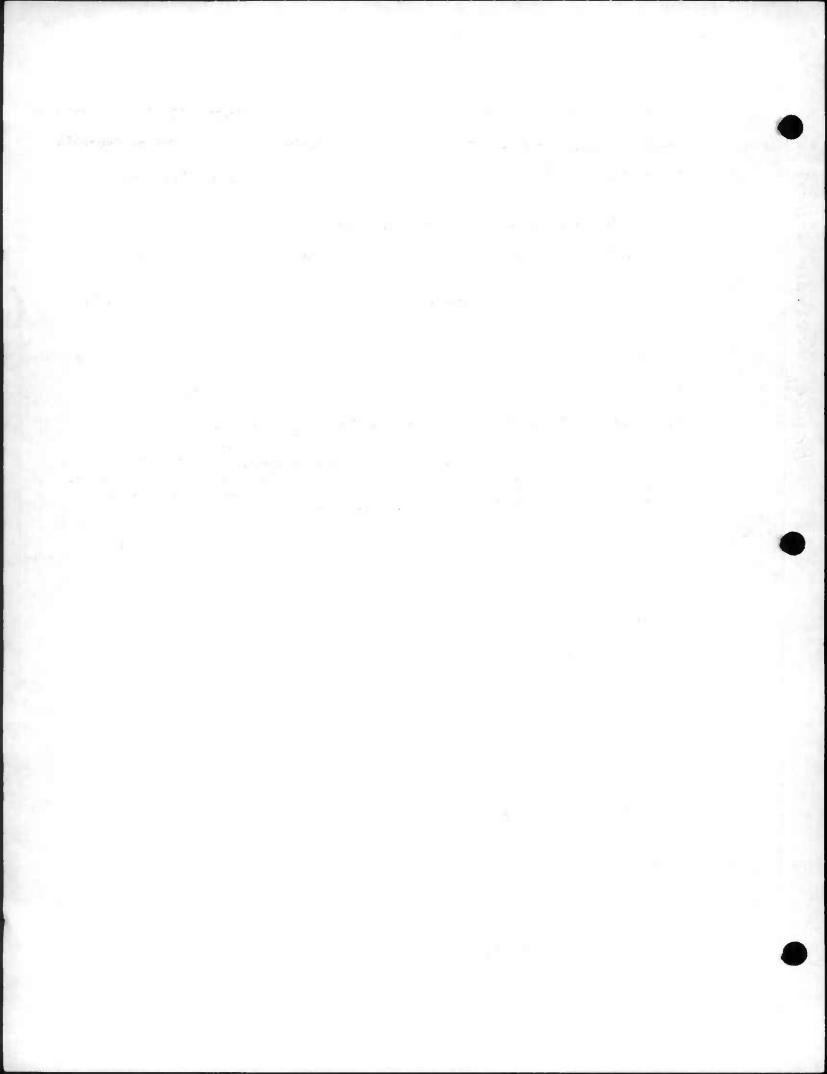
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



"natural", or items 23a or 28a-f show adical Examiner must be notified at uld be filed within 72 hours efter death v Aentel Hygiene. rked other than "natural", or items 23 land 21215-0020

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

Be

17. Fether's Neme (First, Middle, Last)

Isadore D. Hecht

**Funeral** 

Director

Man	s i end 2 sho f Health end h tem 27 is ma other trauma		19e. Informent's Neme/Relationship Evelyn H., Krame			_				ber, City or Town, hington		
Baltimore,	Pegenent on the surface of the surfa		20e. Method of Disposition 1 ☐ Burlai 2 ☐ Cremetion 3 ☐ 4☐XDonetion 5 ☐ Other (Spec	Themover nom State		Disposition (A y, cremetory o Washi		Iniv :	Aug 19	20c. Location - Washing		
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	Physician /Medical Examiner		23a. Pert1. Enter the disease, or col shock, or heart failure. List ont immediate Ceuse (Finel disease or condition resultino in death)	nplications that caused the course on each line.					or respiratory	errest,		Approx Interve Onset
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	uted d ensit	Examiner	Samuestially list and divisor	D		onsequence	<i>6</i> 1.				- 1	10
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l Re	ysician: The lav is certificate hes director, page 2	Somp							علا	Yes 2 No		1 ☐ Yes
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2	Physician: this certific ral director,	To	1 ☐ Yes 2 No	Hospital: Inpatient	2 ER/Ou	petient 3	DOA Other	4 ☐ Nursing H	lome 5 ☐ Res	sidence 6 🗆 Oth	er (Spe	cify)
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Divis	5 # 5 E	Certification:	3 Suicide 6 Could not determined	28e. Plece of Injury building, etc. (5	- At home, fa Specify)	m, street, fact	ory, office		28f. Location City or To	(Street and Numbown, State)	ber or Ru	rel Route
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tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? s en eutopsy formed? 2 No Yes 1 ☐ Yes 2 ☐ No one) sidence 6 Other (Specify) how injury occurred (Street and Number or Rurel Route Number, own, State) ceuse(s) end menner es steted. date end place, end due to the ceuse(s) 29d. Date signed (Month, Dey, Year)

18. Mother's Neme (First, Middle, Maiden Surname)

Approximate Intervel Between Onset end Death

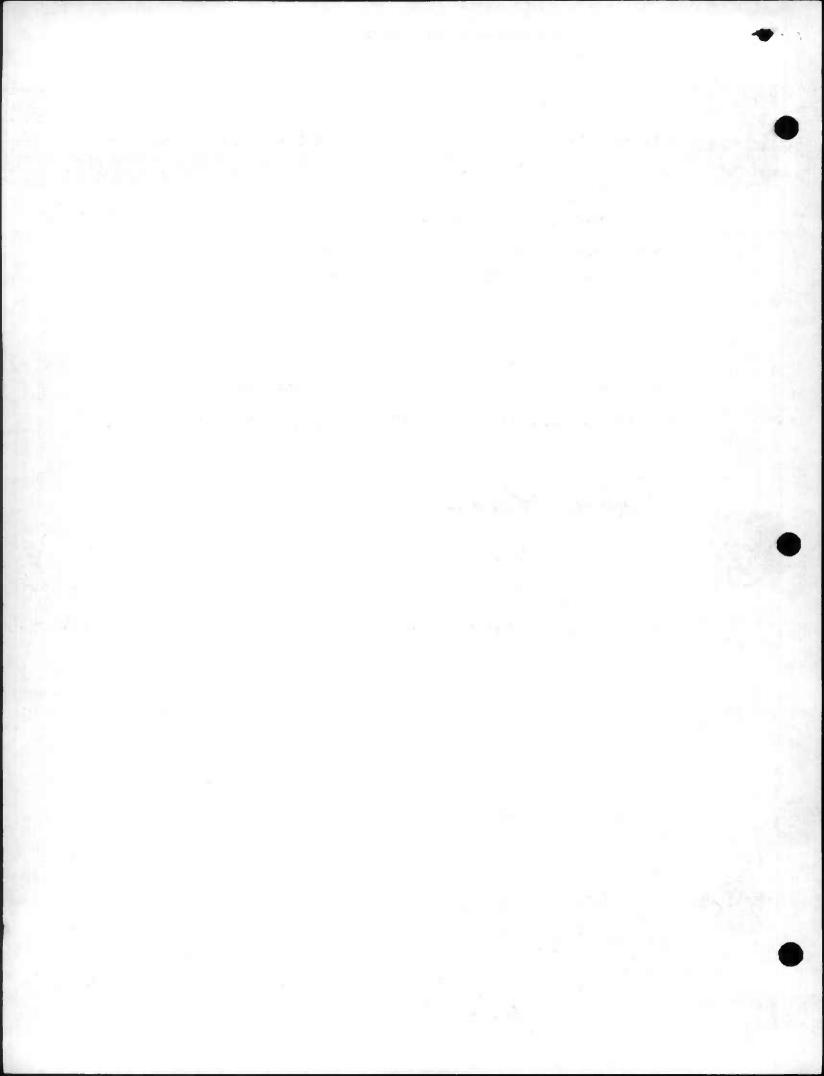
Da Bueville

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Irene Kaufer

Registrar

AUG 2 1 1998



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3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Q | Q 26702 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Hunter August 15 1998 1:47 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Perry Point

H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) VA Maryland Health Care System Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 110 M 2□ F Months 77 Yrs. 410-42-3914 16, 1920 North Carolina Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 200No Maryland Harford Aberdeen Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 614 Carsins Run Road 21001 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. 11 Marital Status Black, Whita, atc. 1∑ Yas 2 No If Yes, Give 1940/45 Year or Dates: 1 Never Merried 2 Married 21215-0020 ò 1 ☐ Yes 2X No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Civil Service Maryland 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Pages 1 and 2 should be fill thrent of Health and Mental H tant; If Nem 27 is marked oth lury or other traumatic even 89 Wade Barker Amanda Hall 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Elva Barker (Spouse) 614 Carsins Run Road, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Harford Memorial Gardens 8/19/98 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Nama and Addrass of Facility
Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 Aberdeen, Maryland 21001–3.

23a. Part1. Enter the disease, or complications that caused he death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 Day Aspiration Pneumonia Examiner Due to (or as a consequence of) Examine 6 Days Cerebrovascular Accident attending physician and for use as the burlatransit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Coronary Artery Disease 3 Years Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown signed b Benign Prostate à 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Hypertrophy 1 Yes 2 No 1 Yas 2 No After this certificete Attending Physician: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only ona) To Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yas 2 ☒ No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural 1 Yas 2 No e Hospital or Attendit n 24 hours efter death, e Funeral Director: Al deeth. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Mosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certified 98 ME:0066318 2001 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) DR Omar PEREZ, MD. VA Maryland Health Care System, Perry Point, MD.

**DHMH 16 Rev 6/95** 

State Registrar

31. Dala filed (MA) (Pay 1 77) 1998

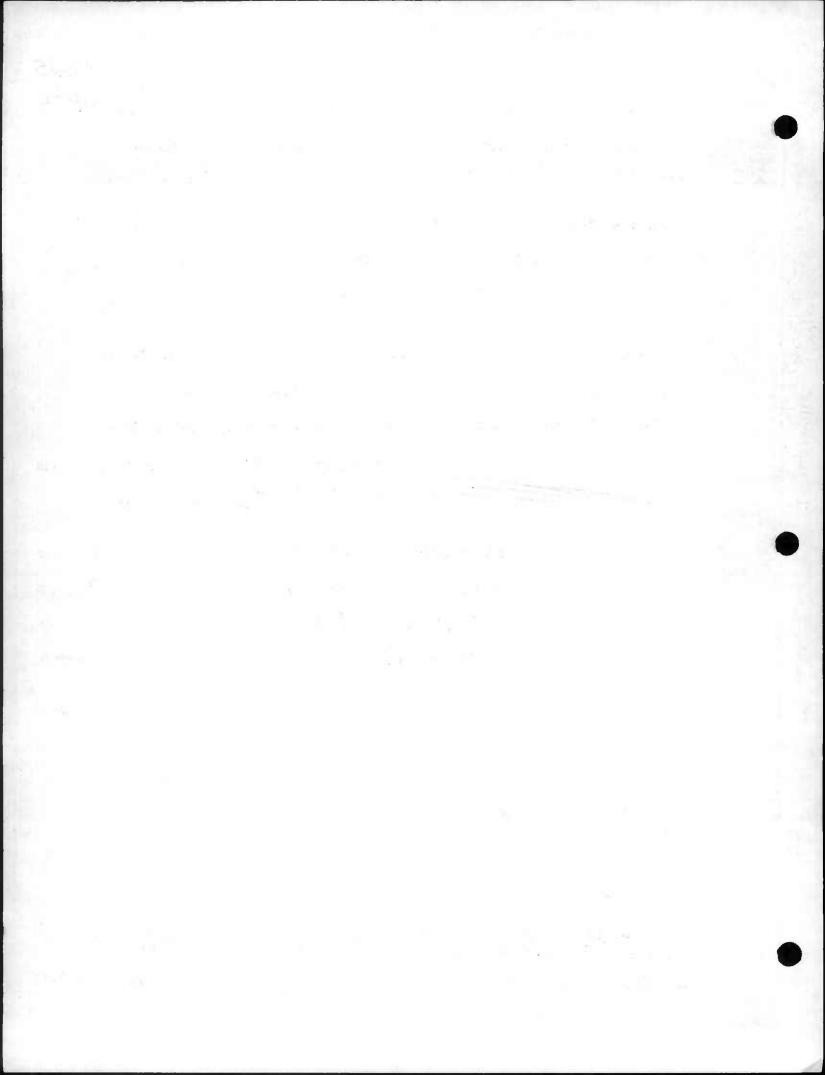
32. Registrar's Signatura

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Fima of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month Willie Brown 08 06 1998 /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Atlantic General Hospital Worcester If Under 1 Yaar 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Yeer) Birthpleca (Steta or Foreign Country) **Funerai** 1 M 2□ F Deys Hours Yrs. 221-34-2675 Director 73 Feb. 18, 1925 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Melaware Sussex Selbyville 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? must be n 19975 Funeral shady Grove Apt. 38 USA 12. Was Dacedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11. Marital Stetus 14. Race - American Indien, event, the Medical Examiner Black, White, etc. 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 6 1 ☐ Yes 2X No þ Specify. 3 ☐ Widowed 4 ☐ Divorcad Black Completed 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sanitation 4th Sanitation O. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be 2 Dan Brown Unknown Lucy 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Department of Health a Important: If them 27 is any injury or other tra Rosie Hall (step daughter) Rt. 3 Box 54B, Frankford, Delaware 19945 Iltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State Data Pages 1 StBurial 2 Cremetion 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Spacify) Calvary Cemetery 8/8/98 Bishopville, Maryland 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 23a. Pert1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disaase or condition resulting in deeth) /Medical Examiner Examiner tha death certificate be executed physician and the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (d es e consequence of) LUIC Physician/Medical to (or es a consequence of) for signed by the a Pert II. Other aignificent conditiona contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were eutopsy findings evailebla prior to completion of ceusa of deeth? 24e. Was an eutopsy performed? Completed peen paga 2 s 2 No cartificata 1 ☐ Yes 2 ☐ No Division of Vital I or Attending Physician: after death. Director: After this carifice director. 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No Inpatiant 2 ER/Outpetient 3 DOA funeral 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo complataly filled in by the 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Hospital of 24 hours a
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Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Funer			. Sex 7.	Age (In yrs. last bi	Mo	Under 1 Year			Birth Day, Year)	Birthplace (State or Fore Country)
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or 28	Direc	10e. Street and Number			10	0f. Zip Code			10g. Citizen of	What Country?
s 23s	erai		APT 3B		10.14	21158		42 4 4	UNITED	
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E C/ 10 10 18		19a. Informant's Name/Relationship	(Type, Print)		-		t and Number of	Rurel Route Num	ber, City or Town,	, Stete, Zip Code)
C - OI .		ELLEN BLACK/WIFE		20b. Place of			AY APT.3		NSTER MD	
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State Registrar 31. Date filed (Month Cay, Year) 1998

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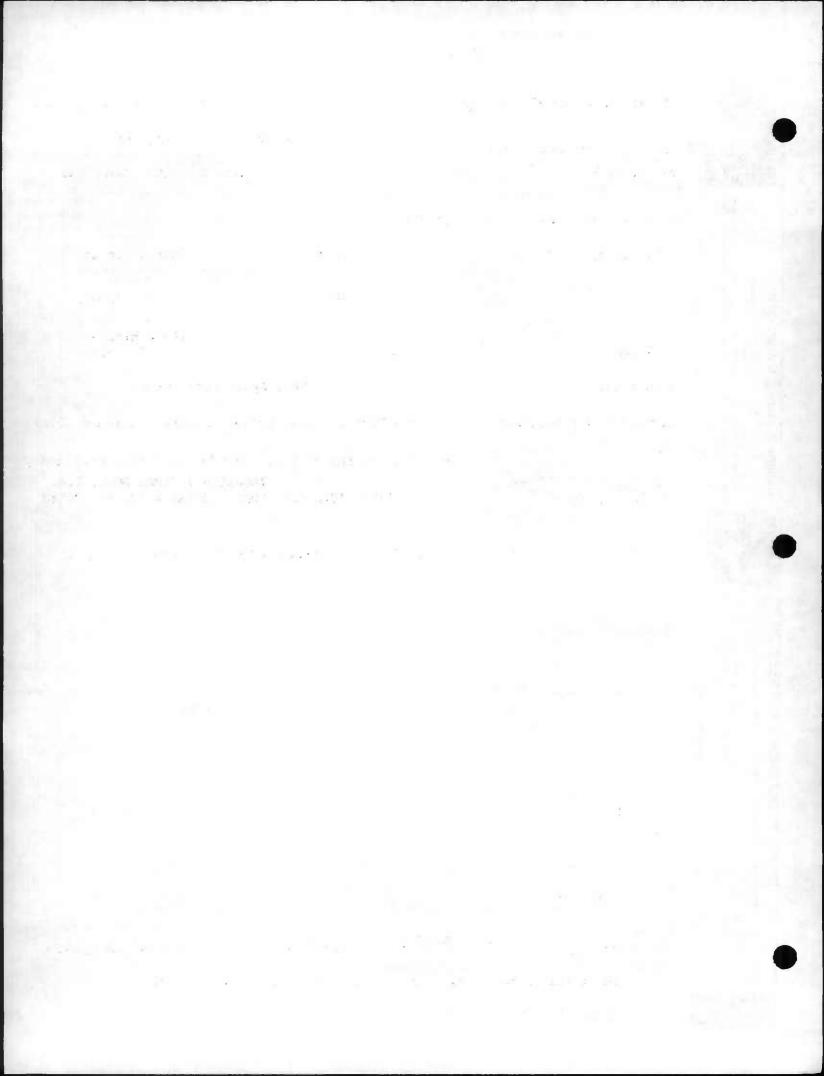
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Deta of Death <sup>Dey</sup> 20 1998 AUGUST **Physician** KENNETH VINCENT BUTLER 8:45AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CHARLES LA PLATA 7870 FAIRGOUNDS ROAD If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year Min. June 2, 19 Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 X 2 F Months Yrs. 216-30-4556 65 Maryland Director Usual Rasidence of Dacedant with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health end Mentel Hygiene. Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be notified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2X No Directo Maryland Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7870 Fairground Road 20640 United States Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ② No If Yes, Give Year or Detes: 14. Race - Amaricen Indien. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Ricen, etc.) Bteck, White, etc. 1 ☐ Never Married 2 M Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuat Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) State Highway Elementary/Secondary (0-12) College (1-4or 5+) 10th Laborer Administration 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnema) John Butler Mary Agnes Bond Butler 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Retetionship (Type, Print) Samassa Law / Daughter 7808 Tinkers Creek Drive Clinton, Maryland 20735 Baltimore, 20b. Ptece of Disposition (Neme of cematery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Buriat 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart Church Cem. 8/25/98 La Plata, Maryland 22. Name end Address of Fecility THORNTON FUNERAL HOME, P.A. 21. Signature of Funeral Service License Leon Thornton 3439 LIVINGSTON ROAD INDIAN HEAD, MD 20640 23a. Pert1. Enter the diseasa, or complications that causad the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate tntervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final PROSTATE CANCER WITH METATASIS TO LIVER Mo disaasa or condition resulting in deeth) Examiner Dua to (or as e consequenca of) Examiner sician end buriel-transit certificate be executed Sequentially list conditions, if eny, laeding to immadiate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest Due to (or as e consequence of): Box 68760 physician Physician/Medical the Dua to (or as a consequence of): 80 use Por 23b. Did tobacco use contribute to the cause of death? ed by the detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. signed by t 1 Yes 2 No 3 Probably 4 Unknown PV 24b. Were eutopsy findings eveitable prior to completion of cause of deeth? Completed 24e. Wes en autopsy peen has page 2 1 ☐ Yes 2 ☐ XNo 1 ☐ Yes 2 ☐ No certificete Division of Vital Attending Physician: funeral director, Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Deeth 28a. Date of tnjury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Panding efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 6 24 hours e 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es steted.
2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) To the To the To the I 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) Y D28352 AUGUST 20, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD 20646 31. Dete filed (Month, Day, Year)

Registra

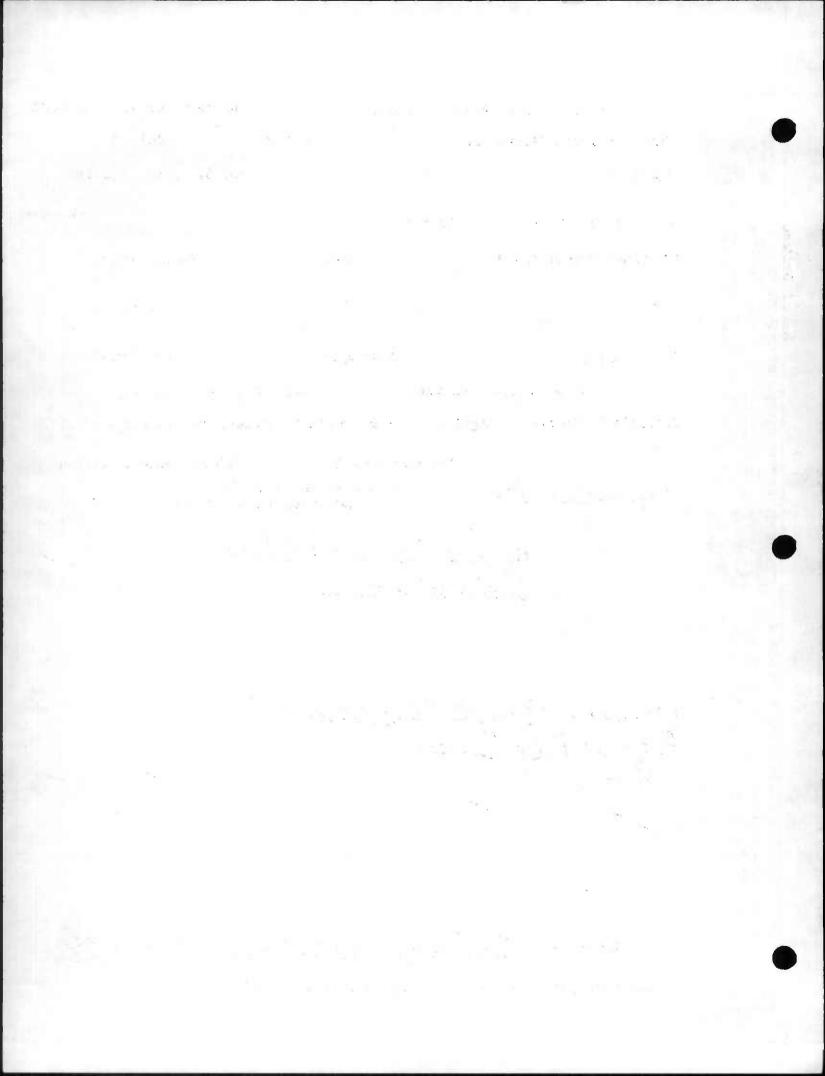
AUG 21 1998

32. Registrer's Signeture



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Neme (First, Middle,	Last)		Certifica			2. Dete of Deeth			3. Time of Deeth	
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/Medical Examiner	4e Fecility Neme (If not institution,			LOWITE		4b. City, Town, or	Location of Deeth	4c. County of			
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r items 23.	1 Never Married 2 Marrie	Armed Ford  1 Yes If Yes, Gir					to Rican, etc.)		, White, etc	2.	
by	3 Widowed 4 □ Divorced	If Yes, Gr Yeer or D	ve*	1 ☐ Yes	2/2 No	Specify:		Cauc	asian		
r, the Medical	15. Decedent's (Specify only highest	Education	16	Sa. Decedent's Usu	el Occup	nation	orkina 1	6b. Kind of Bus			
mple	Elementery/Secondary (0-12)	College (	1-4or 5+)	life. DO NOT	se retire	during most of wo d)					
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uland	4 Donetion 5 Other (Sp. 21. Signature of Funeral Service L	**	Dent	on Cemete	-	ess of Fecility	8/22/98	Denton	, Mar	yland	-
important: Il any injury o once.	21. Signature of Funeral Service L	nn.	rh. a			eral Home	e, P.A.				
	Mariogra	E/1100	NE	12 Sc	outh	Second S	St., Dento	on, MD			
	23a. Pert1. Enter the disease, or of shock, or heart failure. List o	omplications that only one ceuse on e	eaused the deeth. Li each line.	o not enter the mo	ae of ayı	ng, such es cardia	ic or respiratory erre	51,	le le	pproximete ntervel Between 2nset end Death	
sician edical	Immediate Cause (Final	Λ		Da	1	I - /	1 0		6	DOVE	
niner	disease or condition resulting in death)	· TC	ute	KENO	al .	Iail	110		82	1	-
ē		0.	a la sur lo cor as	a consequence of						,	
buriei-transit	Saguestially list conditions	b. 200	Bug to for as	a consequence of							
Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury		Semanta and								I
edical	Ceuse (Diseese or Injury thet initiated events resulting in deeth) Last	C	Due to (or as	a consequence of)	:						-
	resulting in deetin) Last										
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sici	Part II. Other significant condition	s contributing to d	eath but not resulting	g in the underlying	cause gi	ven in Pert I.	23b. Did tol	pacco use con	tributa to ti	he causa of death?	ĺ
page 2 should be deteched for use Completed by Physician/M	Brivary	tra	it -	LIFE	ti	01	1 □ Ye	s 2 UNG	3 Probal	bly 4 Unknown	
isigned by the elid be deteched for	1 4 - 1/4	-1- 1	1 4-				24e. Wes en	eutopsy	24b. Were	e eutopsy findings	-
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duc	Pie	-					1□ Ye	s 20No		Yes 2010	
or, page	25. Was case referred to medical	oria				26 Place of D	eeth (Check only one		- 101	100 222110	
I director, pag To Be Co	exeminer?	Hospitel:	Inpatient 2□ER/	Outpetient 3 D	OA OI	her:	Home 5 Reside		r (Snacity)		
	27. Manne of Death	28e. Dete		o. Time of	28c. Inju Wo		28d. Describe ho				
e funer ation	1 Netural 5 Pending 2 Accident Investiga		in, Dey Year)	Injury M		rk7  Yes 2□No					
ed in by the funera Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Plece	of Injury - At home, ing, etc. (Specify)	farm, street, fecto	ry, office		28f. Location (Str City or Town	eet end Numbe State)	er or Rurel F	Poute Number,	-
d in	4 D Hornicide	Duild	ng, etc. (Specify)				City of Town	Jule			
pletely fille edical (	29a. Certifier 1 Certifying (Check only one)	caminar: On the b	best of my knowled asis of exemination ner steted.	lge, deeth occurred end/or Investigation	t et the ti	me, dete end plec opinion, death occ	e, end due to the ce curred et the time, de	use(s) end me ite end plece, e	nner es stet and due to th	ted. he ceuse(s)	
To the Funeral Director: A completely filled in by the fi	29b. Signeture end title of certifier	and man	)	25	c. Licen	se number	29	d. Date signed	(Month, De	ey, Year)	
- 8	Lamo	XX	e San	7 1	1	3/2 7	6	0-	100	70/	
	30 Name and Allege of same	ho completed accord	on of death //www.co	(Type Brit)	1	171	0	0 0	1	0	_
	30. Name end address of person w				Marr	1and 21	629				
	James Sides, N 31. Date filed (Month, Day, Year)				rat y	Tanu ZI	023				
State	31. Date filed (Month, Day, Year)	JE. I	legistrer's Signeture	/							

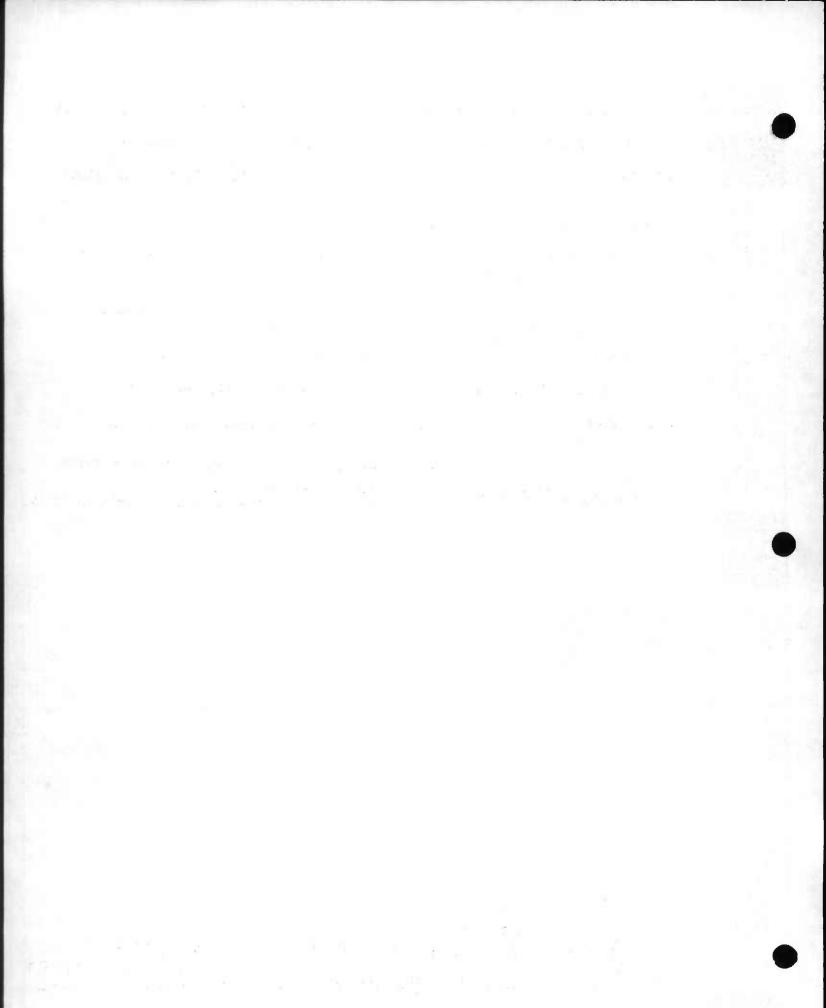


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month Day Yaar **Physician** AUGUST 15 1998 6:45PM Rebecca Mae /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CAROLINE NURSING HOME, DENTON CAROLINE If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 6. Sax Birthpleca (Steta or Foraign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 10 M 20 F Yrs. Director 218-20-7319 72 June 27, 1926 Maryland Usual Rasidance of Dacedant pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Medical Exercises must be notified 2008. 10e. Steta 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Director Maryland Caroline Denton 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 111 Martha Jane Street 21629 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yas, Giva Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 PNo Specify by 3 ₩ Widowed 4 Divorced Caucasian Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Trucking 11 HS Grad. Accountant 17. Father's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be David Eunice Pansy Rogers William Betton 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Philip Brown 25476 Adams Landing Road, Denton, Maryland 21629 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Steta 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 8/18/98 Denton Cemetery Denton, Maryland 21. Signature Lunaral Service Licensee 22. Nama and Addrass of Facility
Moore Funeral Home, P.A. blef. Moore 21629 12 South Second Street, Denton, Maryland 23a. Pert1. Entar the disease, or complications that ceused the death. Do not entar the mode of dying, such as cerdiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Due to (or es a consequance of) Examiner attending physician and for use as the burial-transit The law requires that the death cartificate be asscuted Sequantially list conditions, if any, laading to immediata ceusa. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as e consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be detached 23b. Did tobacpo use contribute to the cause of death? NU VOS 2 No 3 Probably 4 Unknown by 24b. Wara eutopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed s cartificata has t director, page 2 s 2 LN6 1 ☐ Yas 2 ☐ No Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this carifica director, Be 25. Was cesa referred to medicel 28. Place of Death (Check only ona) Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 1 ENatural 5 Panding 1 ☐ Yas 2 No 2 Accident Invastigation n 24 hours after de re Funeral Directo bletaly filled in by ti 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifiar To the Hosp within 24 hou To the Fune completaly fil Medical 29b. Signature and little of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 30. Nema and address of parson who completed cause of daath (Itam 23a) (Type, Print) 9200 James 31. Deta filed (Month, Day, Year) 32 Registrer's Signetura State AUG 1 9 1998 Registrar

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 14 0911 JACK PAUL CRAIG 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL 8. Dete of Birth (Month, Day, Year) DEC. 15, 1 If Undar 1 Yaer If Undar 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days XXM 2□ F Months Hours Min 78 Yrs. 1919 KENTUCKY 301-03-5978 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes XX No MARYLAND MONTGOMERY SILVER PSRING 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20905 U.S.A. 13 MONTFORD COURT 12. Wes Decedent Ever in U,S. Armed Forcas? 1∑Yes 2 □ No If Yas, Giva Yeer or Dates: WWII 14. Race - American Indien, 11. Maritel Status Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) Black, Whita, atc. 1 Never Merried 2 X Married 1 ☐ Yas 20 No Specify: Specify: WHITE 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Spacify only highast grada complated) Collega (1-4or 5+) Elamantary/Secondary (0-12) 5+ BECHTEL CORPORATION ELECTRICAL ENGINEER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) ELEANOR SANTELL WILLIAM CRAIG 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 13 MONTFORD COURT SILVER SPRING MARYLAND 20905 VIRIGINIA ANN CRAIG (WIFE) 20b. Place of Disposition (Nama of cametary, cramatory or other place) ST. MARK'S EPISCOPAL 20a. Mathod of Disposition ✓ Burial 2 □Cramation 3 □Ramoval from Stata AUG. 18 20c. Location - City or Town, Stata 5 Othar (Specify) 4 Donation 1998 SILVER SPRING MARYLAND 21. Signature of Fune al Sarvice Line 7 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-2391 Party Entar tha disaesa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina. Approximata Interval Batween Onsat and Daath Cordopher Immediata Causa (Final disaasa or condition rasulting in daath) LessIVQ Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 Tyes 2 No 24b. Wara autopsy findings eveilable prior to complation of causa of daath? 24a. Was an autopsy 2 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Daath Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 ☐ Accidant 6 Could not be datarminad 3 ☐ Suicida Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 Homicide

physician and s the buriel-transit certificate be executed P.O. Box 68760. Ses 9SU ö signed by the e Records, page 2 certificate Division of Vital or Attending Physician: this funeral After efter death. 24 hours Hospital

Physician/Medical by Completed Be To Certification: edicai

**Physician** 

Examiner

Directo

Funeral

by

Completed

Be

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Examiner

**Funeral** 

**Director** 

r Herre 23e or 3 kner must be n

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"natural"

Pages 1 and 2 should be fill ment of Health and Mental H ant; if item 27 is marked off jury or other traumatic even

Department of important: If any injury or once.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0020

the Medical Examiner

/Medical

completely within 2 To the To the 10

> State Registrar

29a. Cartifiar

(Check only one)

29b. Signature end titla of certifian

29c. Licansa number

(\*\*Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

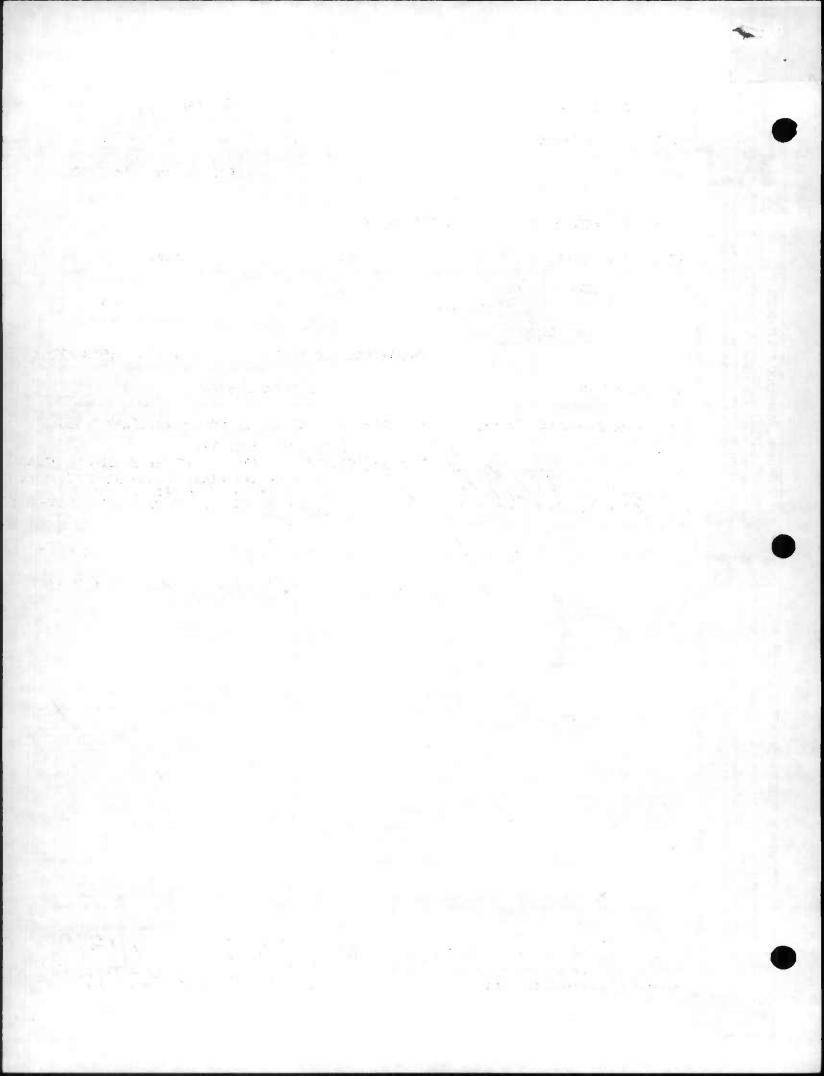
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Data signed (Month, Day, Year)

30. Nama and addras tad ceusa of daath (Itam 23a) (Type, Print)

707

31. Data filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

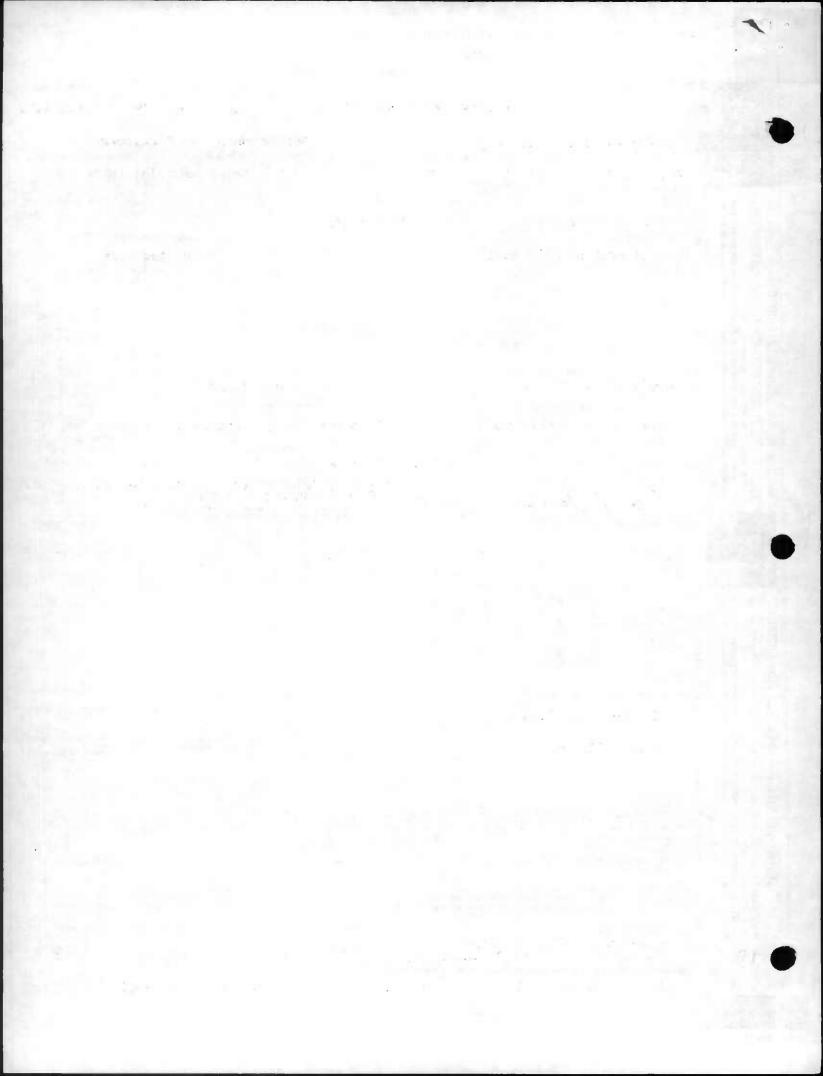


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	Physicia: /Medica	n	Decedant's Nama (First, Middle, Las		inia M	arie Ca	rlisle				2. Dete of De Month August	11, 1	Yaar 998		a of Death  2 A.M.
	Examine	_	4a Facility Nama (If not institution, give					4			ocation of Dear		ty of Death		
			Mediplex of Gait  5. Social Sacurity Number 6. Se	-	7. Age (In yrs.	Inct hirthday)	If Undar 1 Y	Vaar	Galt If Undar:		burg		gomer	-	ta or Eoraica
ı	Funeral Director			_M 2⊠F		30 Yrs.		ays	Hours	Min.	8. Data of Bi (Month, Di	ay, Year) 6, 1918	Cou	io	ta or Foraigi
		-	Usual Residance of Dacedant								101011	, 1710	011	10	
	how		10a. Stata 10b. County		10c. Ci	ty, Town or Loc	ation								a City Limits
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	ith th	Director	10e. Street and Number				10f. Zip Co					10g. Citizan of			
	ath w	ē	19301 Watkins Mi				208					United			
020	within 72 hours after death with the Maryland ena. than "natural", or items 23e or 28e-f show the Modical Evantine must be notified at	2	11. Marital Stetus  1 □ Navar Married 2 □ Marrted  3 ☒ Widowed 4 □ Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Yaar or Do	2 2 No a	lf.	Yes, specify  Yes 2   Yes 2	Cuba	Specify:	gin? (Sp. i, Puerto	ecify Yes or N Rican, atc.)		ace - Amari ack, White, ify: Whi	atc.	1,
Maryland 21215-0020	n 72 hours	Completed by	15. Decedent's Ed (Spacify only highast grad	ucation		(Giva k	int's Usuel O	done o	during most	t of work	ing	16b. Kind of			
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and	Se de p	ď	Orville Samuel G	reen							illon	.,	,,,,		
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re,	ーエック	1	20a. Mathod of Disposition		2001	Place of Dispos cemetery, cram	141 /41	-4				20c. Location			
m	Pages nent of l int or o		1 ☐ Burial 2 ☒ Crametion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ntgomer						Bethes	da. M	arv1	and
Baltimore,	permit. Page Department of Important: If any Injury of pnce.		21. Signature of Funeral Service Licen	000			-					l Home/			
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п	0.21 51		23a. Part1. Enter the disease, or comp shock, or heart feilura. List only	tications that c	aused the dea	th. Do not anta	r tha moda o	of dyin	g, such as	cardiac	or raspiratory	arrast,		Approx	mata Batween
а	Physician		Stock, of tipate tollara. Else only t	714 04034 OI1 4	aori mia.									Onsat a	ind Daath
4	/Medical Examiner		Immadiate Cause (Final disaasa or condition	a C	erebro	vascula:	r Acci	de	nt					2 hou	ırs
н	100		resulting in death)		Dua to (	or as a consequ	ance of):								
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68760,		edicai	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events	c	Due to //	or as a consaqu	ence of):			144					
68		2	rasulting in death) Last		200 10 10	or as a consaqu	01100 017.						1		
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Division	s after death. If Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director: All Director	Certification:	3 Suicida 6 Could not be 4 Homicida datarminad	28a. Place	of Injury - At h	oma, tarm, stra	at, factory, o	office				(Streat and Nur own, Stata)	n <i>ber</i> o <i>r Rui</i>	ral Route	Numbar,
		edical	29a. Certifiar (Check only one) 1⊠ Certifying Phy	Iner: On tha ba											sa(s)
	To th To th comp	-	29b. Signatura end titla of certifier				29c. L	icens	e number			29d. Date sign	ned (Month	Day, Ye	ar)
	10		ce G	200	e_		D	3	344	3		Argus	+ 11,	199	8
			30. Name and addrass of person who o												
			Alan R. Pollack,	M.D.	809 Ve:	irs Mil	1 Road	1,	Rockv	ille	, Mary	land 2	0851		

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Dey, Year) AUG 18 1998

32. Registrer's Signatura



crn David Willia	m J	ohn Carter					nd / De	epartr	nent o	f He	alth an		ental Hy			2 (	57	10
ITEMS: #	23 F	PART I, 27 PE	ER MEO G	3763 9-3	-98 WR	₹.	C	Certifi	cate c	of D	eath			Reg. N	lo.			
		1. Decedent's Name	e (First, Midd	ile, Last)				1775					2. Dete of De			Year	3. Tin	ne of Death
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/Med		4a Facility Neme (I	f not institution	on, give stree	t end numi	ber)				4b.	City, Town		ation of Death		c. County			20 11411
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Funero	,	5. Social Security N		6. Sex		. Age (In yrs	. lest birtho		Under 1 Ye	ear I	f Under 24		8. Date of Birt (Month, De					ete or Foreign
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		Usuel Residence of											000	, -	.700	, wasi.	11116	con, D
/lanc		10e. Stete	10b. County	у		10c. C	ity, Town o	or Locatio	n							1	0d. Insid	de City Limits
020 Aurs effer deeth with the Meryland al, or items 23e or 28e-f show Examiner insults notified at	to	Maryland	Monts	gomery			Bet	hesd	а								1 🗆	Yes 2X No
the	Director	10e. Street end Nur		, ,				1	of. Zip Cod	de				10g. C	itizen of \	Whet Cour	ntry?	
oth with		7607 Ger	anium	Stree	t					208	317			Un	ited	Stat	es	
eeth me 23	Funeral	11. Maritel Status		12. V	Vas Deced	lent Ever in I	U.S.	13. Wes	Decedent	-		? (Spec	cify Yes or No			e - Americ		en,
ē 22	5	1 Never Merri	ed 2□ Mar	-	rmed Ford	ces?	,,,,	If Yes	s, specify C	Cuben,	Mexican, P	uerto F	cify Yes or No- tican, etc.)		Blee	ck, White,	etc.	
78 of	by	3 □ Widowed			Yes, Give			101	res 2⊠	No .	Specify:				Specify	" Whi	te	
				nt's Educetio			16a D	ecedent's	s Usuei Oc	ccupetio	on			16b.	Kind of B	usiness/Inc		
21215-0020 within 72 hours effer giene.	Completed		ify only highe	est grade cor	npieted)		((	Give kind ife. DO N	of work do IOT use re	one dur	on ing most of	f workin	g				,	
with	E C	Elementery/Seco	ndary (0-12)		College (1-4	4or 5+)			dent					S	choo	1		
d 2 Hygid		17. Fether's Neme	/First. Middle.	Last)				500	delle	11	B. Mother's	Neme	(First, Middle,					
d be do	Be	Jeremy V									Fran	Chi	ttlebo	ron	gh			
Maryland 21215-0 nd 2 should be filed within 72 hd lith end Mental Hygiene.  27 is marked other than "netur treumatic event, the Medical	5	19a. informant's Na			Print		10b A	Mailing As	Idraec /Str	reet on			Route Number			State Zin	Code)	
Ma 12 s 12 s 1 s r																		1 7
e, lend lealt her ther		Jeremy V.		er/rat	ner	20h	Plece of D				treet	, B	ethesd			Land City or To		
OF OF OF		20e. Method of Disp		3 □Remo	vel from St		cemetery,	cremeto	y or other	plece	Aug. 1	L2 ,	1998					
Pe Pe Mant:		4 Donetion	5 Other (5	Specify)		Mo	-				rium,					la, M		
Baltimore, Maryland 2121 pernit. Pages 1 end 2 should be filed within Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, that we have the standard of the standard other than any Injury or other treumatic event, that we have the standard other than any Injury or other treumatic event, that we have the standard other than any Injury or other treumatic event, that we have the standard of the standard other treumatic event, the standard of the standard other treumatic event, the standard other treumatic event, the standard other treumatic event.		21. Signature of Fu	neral Service	Licensee				Robe	me end Ac	ddress	of Fecility	ey F	uneral ue 20814	Но	me/B	ethes	da-	Chevv
7 00 80 5 8 8	5	Kon	13	and		M001	98	755	7 Wis	scor	sin A	Aven	ue 20814	_35	01	Cha	se,	Inc.
Barry		23a. Part1. Enter a shock, or hea	e diseese, o	or complication	ons that car	used the dea	ath. Do not	t enter th	e mode of	dying,	such as ce	rdiac or	respiretory a	rrest,	VI_		Approx	cimate
Physician	,	snock, or nea	rt railure. Lis	t only one ce	euse on ee	ch line.											Onset	end Death
/Medica		immediate Cause (				CEDER	DAI DA	I CV C	OMDI I C	ATE	DV CE	17110	E DISORI	)ED				
Examine	r	diseese or condition resulting in deeth)	n	Θ						AIEL	) DI 3E	11408	E DISOKI	JEK				
	ē					Due to	(or es e co	nsequen	ce or):									
'60, be executed sicien and buriel-trensit	Examiner			b		D		77. 74.6								-		
60, be executed ician and buriel-transit	X	Sequentially list con if eny, leading to im cause. Enter Unde Ceuse (Diseese or	nditions, nmediate			Due to	(or es e co	nsequen	ce or):							I		
60, be ex	20	Ceuse (Diseese or that initiated events	Injury	c											_			
, Box 687 death certificate e attending physical of for use es the	9	resulting in death)	Last			Due to (	or as a cor	nsequenc	e of):									
X Se es	Š			d														
Box sath certi	Physician/Medic															i		
_ 0 0 0	/slo	Part II. Other signif	icant conditi	ions contribu	ting to dea	th but not re	sulting in the	he under	ying cause	e given	in Pert I.		23b. Did	tobacc	co use co	ntribute to	o the ca	use of death
P.O. thet the deby the detached													1 🗆	Yes	2 No	3□ Pro	bably	4 Unknow
dS, P	by															1		
Records, he law requires ti e has been signe	Pe												24a. Was	arı aut	topsy	ev	eilable p	psy findings prior to
aw ra	ple															of	deeth?	n of cause
	Completed												12	Yes	2 No	16	Yes	2□ No
	0	25. Was case refer	red to medica	al							6 Plece of	Deeth	(Check only					
of Vita Physician: ribis certific	Ö	examiner?		Hosp	ital:	patient 2	7 EB/0	otiont 7		Other:			ne 5 Resi		eV104	or (Cnacil	60 at	ccone
0 4 4 2	-	27. Manner of Deet		21			ER/Outp	_			4   Nursi	-	8d. Describe				y/ at	acene
OD OD Odling Ph. After th	tlon:	1 🖾 Naturel	5 Pendi	ing	(Month	Injury , Day Year)	inju		4	Injury e Work?	s 2 No							

To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr

2 ☐ Accident Medical Certifica 4 Homicide 29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) end manner steted.

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29b. Signature and title of certifier

6 Could not be determined

29c. License number 29d. Dete signed (Month, Dey, Year)

O.C.M.E.

August 11, 1998

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

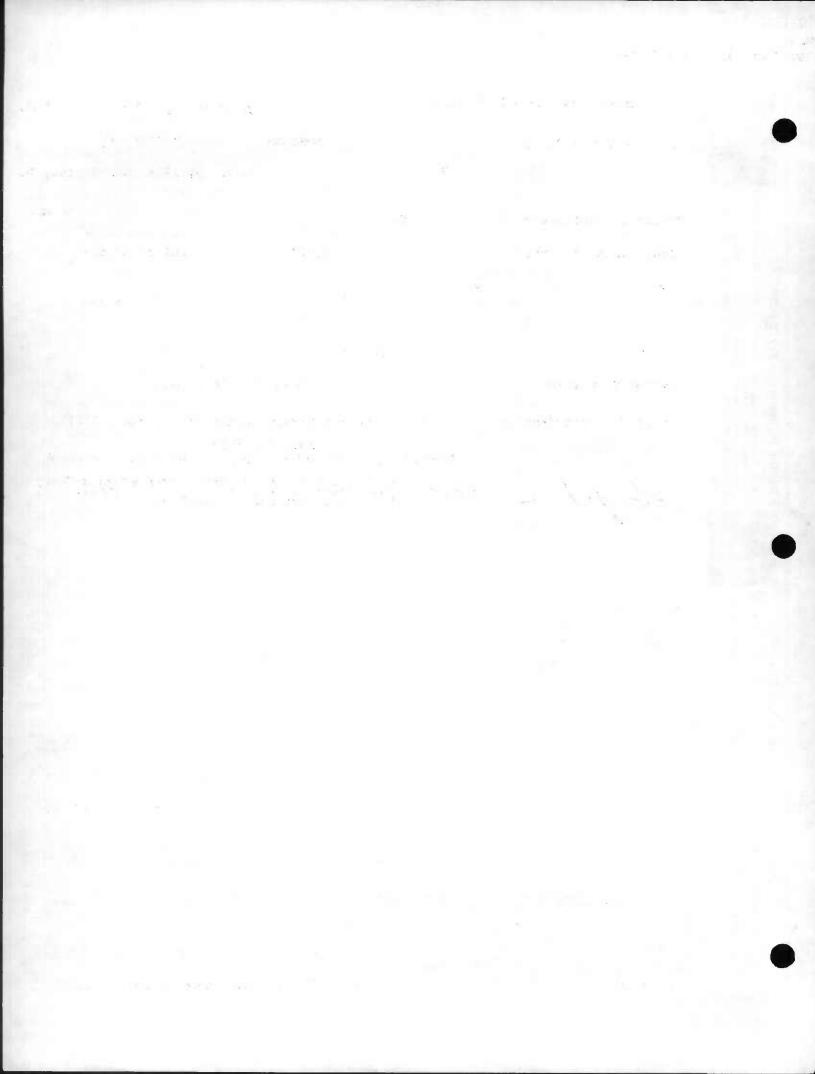
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year) AUG 1 8 1998

111 Penn Street, Baltimore, Maryland 21201

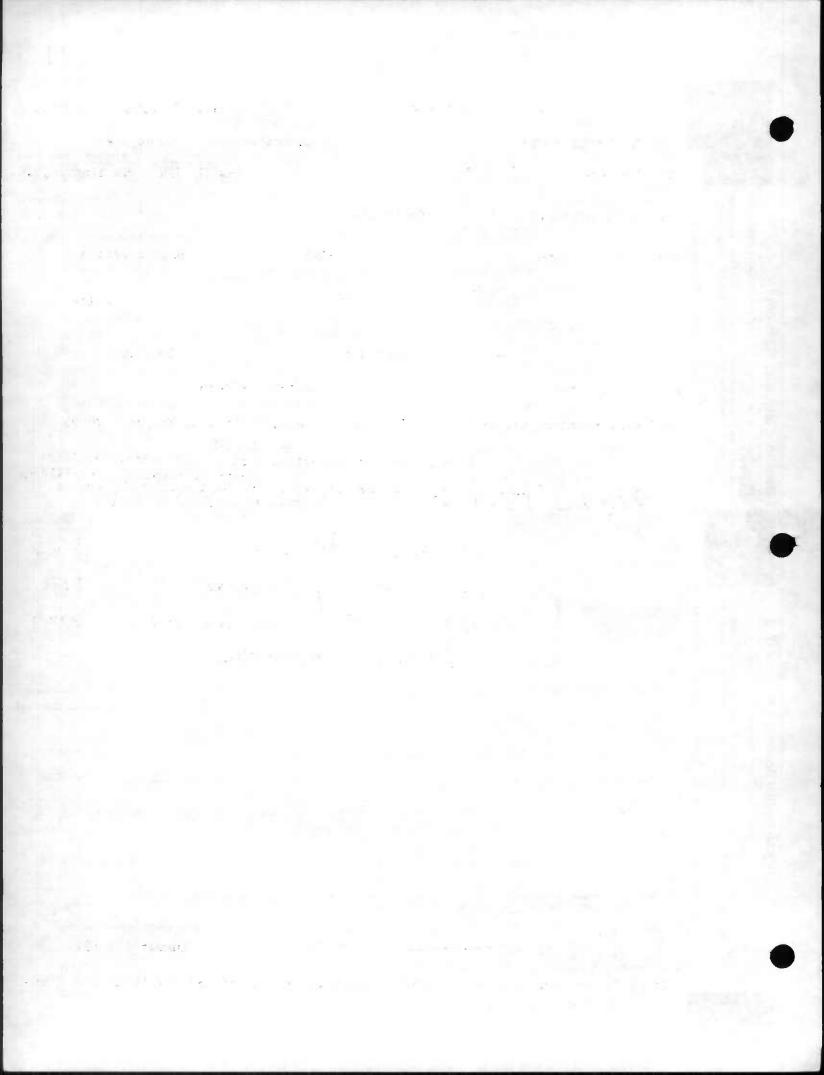
State Registrar

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

				C	ertificate c	of Death			Reg. No.		
		1. Decedent's Neme (First, Middle,	Last)					2. Dete of De			3. Time of Death
	Physician	Jean	D. C	hadwick				Month August	14, 199	Year 8	2:00AM
	/Medical Examiner	4e Fecility Neme (If not institution,				4b. City, To		cation of Deat			2100121
	LAGINITE	5930 Serenity	Lane			Rock	ville		Monte	gomer	U
-	Francis		Sev 7 Age /	In yrs. last birthda	(av) If Undar 1 Ye			8. Dete of Bir (Month, De		-	leca (Stete or Foreign try)
	Funeral Director	577-18-1506	1□ M 2 <sup>th</sup> F 80	Yrs	Months De	ys Hours		June 11		Wash:	ington,D.C.
	p ,	Usual Residence of Decedent  10a. Stete 10b. County	1.	Oc. City, Town or	Location					1/	0d. Inside City Limits
	death with the Maryland one 23e or 28e-f show constituted at neral Director	Maryland Montgom			cville						1 ☐ Yes 2 ☐ No
	or 28	10e. Street end Number			10f. Zip Cod	la			10g. Citizan of	Whet Count	lry?
	h will	5930 Serenity La	ne		20	855			United	Stat	es
	r tems 234	11. Maritel Status	12. Was Decedent Eve Armed Forces?	er in U,S. 1	3. Wes Decedent of	of Hispenic Or	igin? (Spe	cify Yas or No		e - America	
020	urs after	3 X Widowed 4 □ Divorced			1 ☐ Yes 2X I			Alcan, etc.)	Specify		ite
215-0020	72 ho	15. Decedent's (Specify only highest	Education grede completed)	16e. De	cedent's Usuel Oc ive kind of work do e. DO NOT use re	cupetion one during mos	st of worki	ng	16b. Kind of B	usiness/Ind	lustry
12	within "iene." Then "r	Elementery/Secondery (0-12)	College (1-4or 5+)			ureaj			0 11	000	
121	filed with Hygiene. ther than the hart.	12 17. Fether's Neme (First, Middle, La	- met)	HOI	nemaker	19 Moth	or's Nome	/Eiret Middie	Own H		
Jug Sur	should be filed and Mental Hyginmarked other imatic event, I To Be Co							-	, Maluan Sumen	iia)	
Ž	should be and Mental marked o urmatic eve					,		Frain			
Maryland	2 sho end is m	19a. Informent's Neme/Relationship			eiling Address (Str						
	1 end Health 8m 27 ther tr	Janice L. Rotolo	ne/Daughter		Serenit						
more	Pages 1 end tent of Health nt: if Itam 27 iry or other ti	20e. Method of Disposition  1  Burial 2 X Cremation 3  4  Donation 5 Other (Spe			sposition (Neme of cremetory or other ery Crema				20c. Location -		
Baltimore	permit. Pag Department Important: If any Injury o	21. Signature of Funeral Service Li	censee		22. Name end Ad Rockville	dress of Facil	ity Rob	ert A. O West	Pumphr	ey Fu	neral Home
ń		23a. Furth Enter the diffease, or conducting the state of		e deeth. Do not	enter the mode of	Rockvi dying, such es	.11e,	Maryla r raspiratory a	and 2085 arrast,	0-280	Approximate intervel Between
	Physician	0.0			1			-			Onset end Deeth
4	/Medical	Immediate Cause (Final disease or condition	CF	HUDIA	CH	YCKE	35			i	6 min
	Examiner 5	resulting in deeth)	PO	ue to (or es e con	sequence of):	n 6	Au	INP			1 mo
	d ensit	Conventiolly list conditions	b	ia to (or as a con	sequence of):	1 1	7100				
60,	requires that the death certificate be executed een signed by the attending physician end hould be datached for use as the bunal-trensit etc by Physician/Medical Examiner	Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Couse (Disease or Injury that initiated events	c. M	ETAS	20110	- W	NG	CAN	WIL	•	Zonun.
68760,	entificate be ling physicia e es the bur Medical	resulting in deeth) Last	Du	RV A	sequance of):	MENA	nst	1			
Box	attendir for use		d	01014	7-1		-			1	
	that the death cered by the attending datached for use	Part II. Other significant condition	contributing to deeth but i	not rasulting in th	a underlying ceuse	given in Pert	1.	23b. Did	tobacco usa co	ntributa to	the causa of death?
P.0	t tha de by the tached							1X	Yes 2 No	3 Prot	sably 4 Unknown
	es tha igned be dal										
Records,	w requires that is been signed be date is should be date		Market L	TEN I				24e. Was	s en eutopsy omned?	ave	ere autopsy findings eileble prior to mpletion of ceuse death?
	has has							10	Yes 2000		Yes 2XXXVo
ta	certificate rector, pag	25. Was case referred to medical				26. Plec	e of Deeth	(Check only	one)	1	
>	Physician: this cartificated and director,	axaminar?	Hospitel:	2 ☐ ER/Outpa	tient 3 DOA	Other: 4 N	ursina Hor	ne 5 Res	idence 6 □Ott	ner (Specifi	v)
Division of Vital	After this funeral di	27. Menner of Deeth 1 Neturel 5 ☐ Pending	28e. Dete of injury (Month, Dey )		e of 28c. I	injury et Work? 1 Yes 2	1		how injury occur		
ivisio	tal or Attending P rs efter death. al Director: After t led in by the funers Certification:	2 Accidant investiga 3 Suicida 6 Could no 4 Homicide determin	t be aga Place of Inlus	- At home, farm,					(Straat end Num own, Stete)	ber or Rure	l Route Number,
0	Cer is ed in										
	To the Hospital or Attending Phwithin 24 hours effer death.  To the Funeral Director: After thispenpletaly filled in by the funeral pempletaly filled in Certification: 1	29a. Certifier (Check only one)	Phyeician: To the best of raminer: On the basis of each manner state	caminetion end/o	eeth occurred et the r Investigation, in n	e time, date ei ny opinion, de	nd plece, e ath occurre	end due to the ed et the time	ceuse(s) end m , dete end place,	enner es st end due to	eted. the ceuse(s)
	ithin o the pmpl	29b. Signature and title of certifier			29c. Lic	ense number			29d. Date signe	ed (Month, i	Dey, Year)
	F 3 F	· X	11		D33	109			August	14. 1	1998
	25	1		-		107			August.		
		30. Name end e dress of person w				d Aus D		#150 0	41 mars C		20904
		Adolph Wooth Con Your			Prosper	ity Dr	ive,	#150,S	ilver Sp	oring	, Maryland
	State Registrar	31. Date filed (Month, Dev. Year) AUG 1819	32. Registrer's	Signature	Span	6					



**JOHN** 

CARROLL

State of Maryla

and / Department of Health and	Mental Hygiene 9 8	26712
Certificate of Death	Reg. No.	20112

2. Date of Death

~ ^ ^	THOPP
	Physician
	/Medical
	Examiner

4a Facility Name (If not institution, give street end number)

1. Decedent's Name (First, Middle, Last) F. Carroll

Month AUGUST 3. Time of Death

CIVISTA MEDICAL CENTER

10b. County

4b. City, Town, or Location of Death

21, 1998 2:17P.M. 4c. County of Death

**Funeral** Director

Peges 1 end 2 should be filed within 72 hours efter death with the Maryland neat of Health and Mentel Hyglene. Intent of Health and Mentel Hyglene. Int: If them 27 Is marked other than "neturel", or items 23a or 28a-f ahow mit: If them 27 Is marked other than "neturel", or items 23a or 28a-f ahow ury or other traumatic avent, ma Modical Examiner must be notified at Director Funeral þ

Completed

Be

Baltimore, Maryland 21215-0020

permit. Pege Depertment of Important: If eny Injury or once.

**Physician** 

/Medical

Examiner

physician end s the burial-transit

ettending pl

signed by the e

should b

certificate has b

this funerel

After

ofter deatl Director:

n 24 hou. The Funeral Direction of Filled in

To the H within 24 To the F

Hospital or Attending Physician:

thet the death certificate be executed

Division of Vital Records, P.O. Box 68760

Examiner

Physician/Medical

þ

Completed

Be

To

Certification:

edical

5. Social Security Number 10 M 20 F 262-76-3111

Union

7. Age (In yrs. last birthday) Months 50 Yrs.

10c. City, Town or Location

Lake Butler

LAPLATA if Under 1 Year | if Under 24 Hrs. Days Hours

April 1 1 1 948 Birthplaca (State or Foreign Country)
 TT

> 10d. Insida City Limits 1 Yas 2 □ No

10e. Street and Number

Usual Residance of Decedent

430 N.W. 9th Ave.

10f. Zip Code 32054 10g. Citizen of What Country? U.S.A.

CHARLES

11. Maritai Status 1 ☐ Never Married 2 ☐ Married

10a. Stete

12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give<sup>2</sup> Year or Dates:

 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 ☐ No Specify:

Black, White, etc. Specify: White

14. Raca - American Indian

15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12)

3 Widowed 4 Divorced

College (1,4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Carpenter

16b. Kind of Business/Industry Carpentry

17. Fether's Name (First, Middle, Last)

Steve B. Carroll

18. Mother's Name (First, Middle, Maiden Sumama) Wilma Thornton

19e. Informant's Neme/Relationship (Type, Print) Steve B. Carroll/Son

20b. Place of Disposition (Name of cemetary, cremetory or other place)

430 N.W. 9th Ave. Lake Butler, Fl 32054 20c. Location - City or Town, Steta

20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

cemetary, cremetory or other place.
Dekle Cemetery

8/25/98 Lake Butler, Fl.

21. Signature-of Funaral Sarvice Licensae

22. Nama and Addrass of Facility AREHART -ECHOLS FUNERAL HOME P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest, shock, or heart failure. List only one cause on each line.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Immediate Cause (Final disaese or condition resulting in death)

a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or es e consequence of):

Due to (or as a consaquenca of)

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death?

1 Yes 2 No 3 Probably AMunknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

Approximate Interval Between Onset and Death

1 Yes XX No 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? TV Yes 2□ No

> 5 Pending investigation

6 ☐ Could not be determined

Hospitel: 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Day AUG, 21, 1998

28b. Time of 1300 P M

ROADWAY

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tes 2 XX

Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

PASSENGER INVOLVED IN MOTOR

281. Location (Street and Number or Rural Route Number, City or Town, State) BUDDS CREEK ROAD, NEWBURG, MD.

29a. Certifier (Check only one)

31. Date filed (Mo

27. Manner of Death

1 Naturel

2XXAccident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as stated. Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of oprilie

29c. License number O.C.M.E.

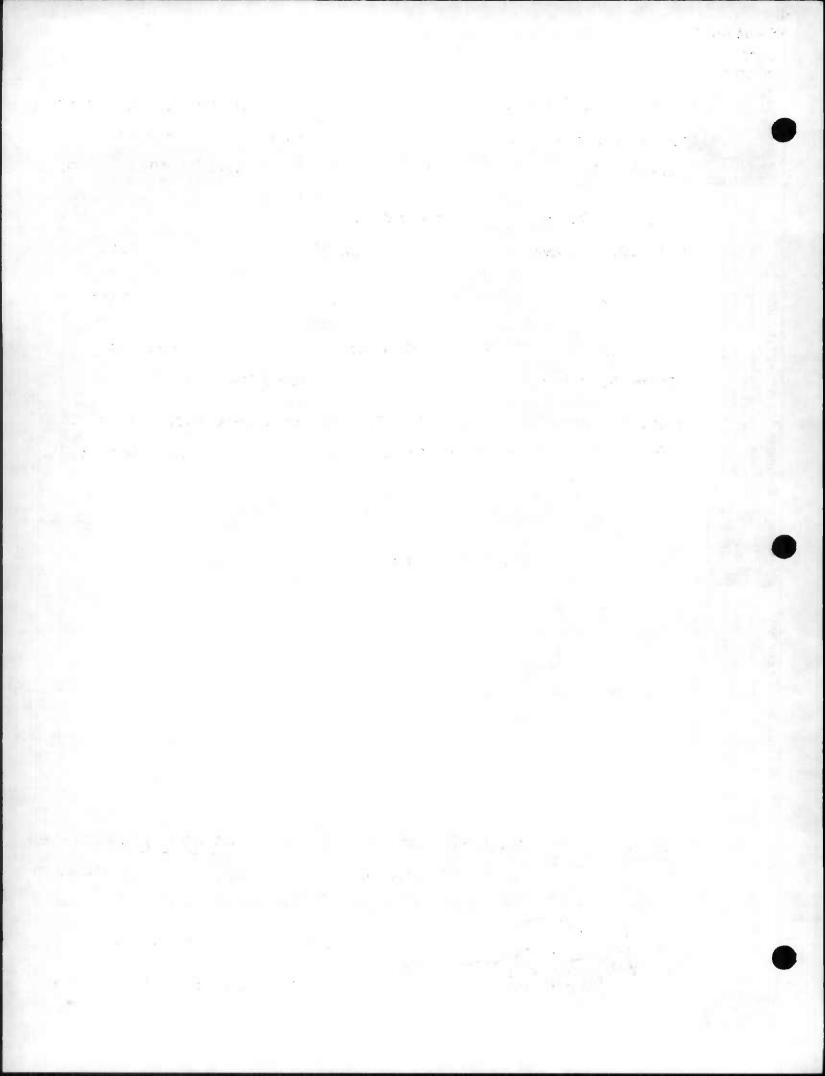
29d. Date signed (Month, Dey, Year) AUGUST 22,1998

cause of deeth (Item 23e) (Type, Print) 30. Name and

111 Penn Street, Baltimore, Maryland 21201

State Registrar AUG 1998 32. Registrar's Signature

backs



State of Maryland / Department of Health and Mental Hygiene

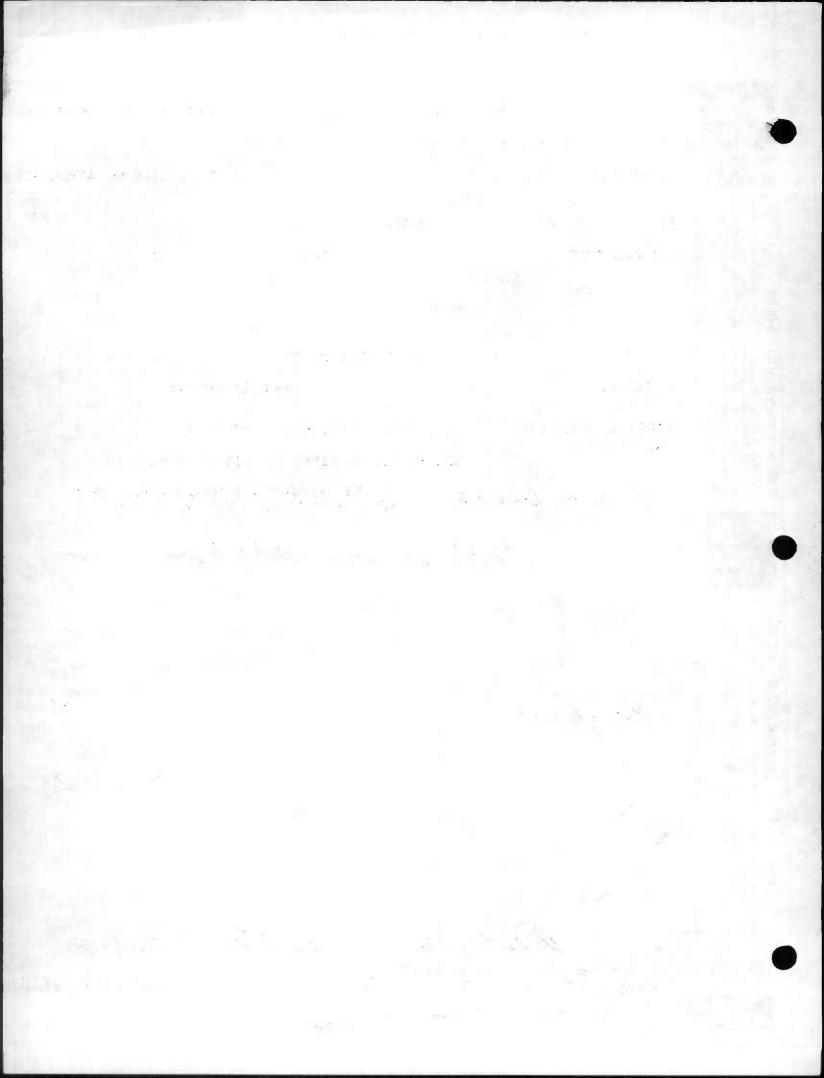
Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Nema (First, Middle, Last) **Physician** John Cole Thomas 14 1998 August 7:08 AM /Medical 4b. City. Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Genesis ElderCare -The Pines Easton Talbot If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthpleca (Stete or Foraign Country) **Funeral** Days 1X M 2□ F Yrs Director 018-09-2212 JULY 29, 1914 MASSACHUSETTES Usuel Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a, Stete 10b. County 1 ☐ Yas 2 No Director TALBOT EASTON 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23s or the Medical Examiner must be a 35 PARK LANE 21601 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ੴYas 2 □ No If Yes, Give Year or Dates: WWII 14. Race - Amaricen Indien, Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. filed within 72 hours after Hygiene. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Spacity: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 -0-FIRE DEPT. DEPUTY FIRE CHIEF pemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If fem 27 is marked othe eny injury or other traumatic avant, bings. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middle, Last) ALBERT COLE MARGARET VANNETT 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 35 PARK LANE, EASTON, MD 21601 Dete 20c. Location - City or Town, Stata JENNIE M. COLE/ WIFE 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 1 XBuriel 2 ☐ Cremation 3 ☐ Removel from State MD. VETERAN CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) 8-18-98 BEULAH, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 230 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the diseesa, or complications that causad tha daath. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one causa on aech line. Approximate Intervel Between Onset end Death **Physician** car conoma metastatic to bone Immediate Causa (Final diseese or condition resulting in death) /Medical years Examiner Dua to (or es e consequence of): Examiner the death certificate be executed ettending physician and for use as the buriel-trans Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by the e 1 Yes 2 No 3 Probably Unknown ancytopenia b 24b. Were eutopsy findings avellable prior to completion of ceusa of death? 24a. Wes en eutopsy performed? Completed certificate has b 1 ☐ Yas 2 No 1 Yas 2 No 25. Wes cese referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After ! or Attending 5 Pending investigation 1 Neturel r death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 6 24 hours efter d • Funeral Direct sletely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. edicai 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and manner steted. (Check only one) To the Within 2
To the Complete 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) AVENUE MD 508 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

Registrar

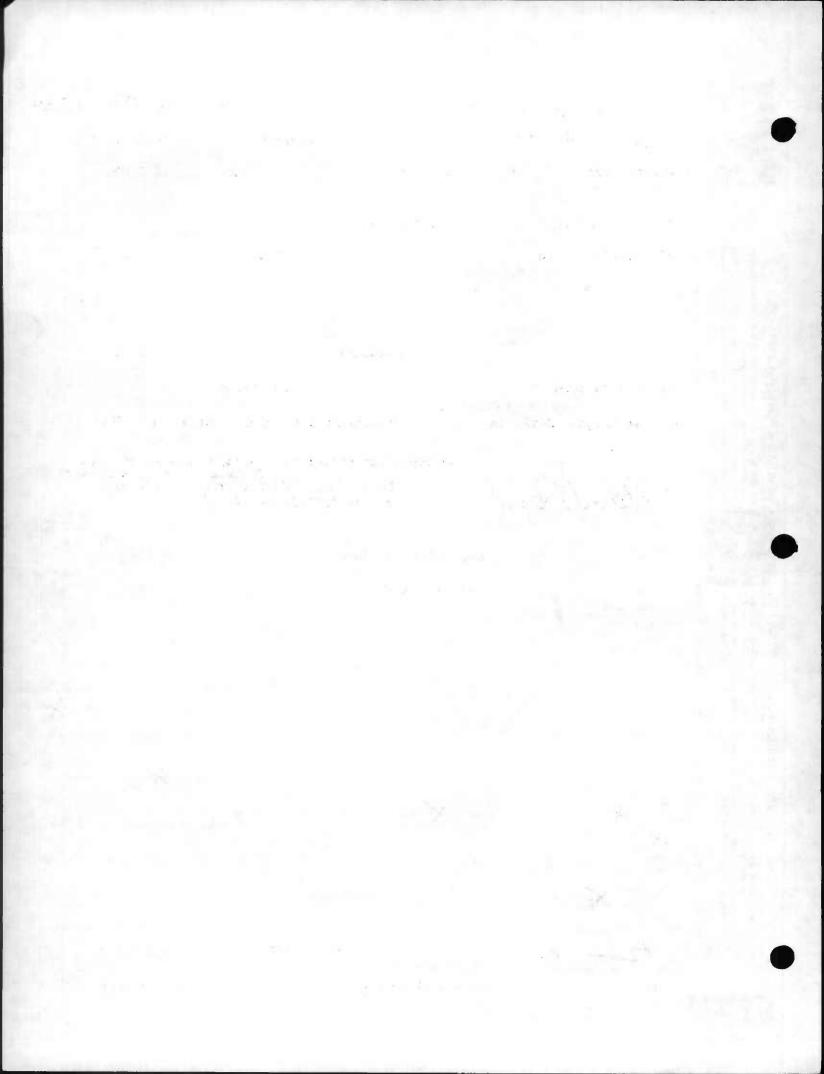
AUG 1

1998



State of Maryland / Department of Health and Mental Hygiene 8 267 14

					Ce	rtifica	te of	Death			Reg. No.	4.0	/ 1	-6
Diameteries.	1. Decedent's Name (First, Midd	lle, Last)								2. Dete of De	eth	_Vear		ne of Deeth
Physician /Medical	Hollace	H. Da	wids or	~						Month	15	98	03	524
Examiner	4a Fecility Name (If not institution	n, give stree	at and number			_		4b. City, Tow	n, or Lo	cation of Deet	h 4c. Cour	nty of Deeth		
	Suburban b	lospita	1					Betre	sda		mo	ntgom	iery	
Funeral	5. Social Security Number	6. Sex		ge (in yrs. la	st birthday	) If Under	r 1 Year Deys	If Under 2	4 Hrs. Min.	8. Dete of Bir (Month, De	th Vest	9. Birthp	placa (St	ate or Forei
Director	293-40-2036	1□ M	201 F	53	Yrs.	MONTHS	Deys	Hours	IVIII I.	Aug. 1	3, 194	5 Ohio		
D .	Usual Rasidenca of Decedant		_											
how	10a. State 10b. Count	/		10c. City,	Town or L	ocation						1		de City Limi
cto cto	MD Mon	tgomer	У	Cł	nevy (	Chase							1	Yes 2⊠N
with the Mar	10e. Street end Number					10f. Z	p Code				10g. Citizen o	f Whet Cour	ntry?	
72 hours after death with the Maryland natural; or Name 23a or 28a-f show state Energies must be notified at steed by Funeral Director	3730 Cardiff	Road						208	15			USA		
n 72 hours after death with the Maryler "natural", or Items 23a or 28a-f show ad cal Examinat must be notif ad all leted by Funeral Director	11. Maritel Status	12. V	Wes Deceden Armed Forces	t Ever In U,S	. 13.	Was Dec	edent of I	Hispanic Origi	in? (Spe	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ		ın,
P. Fu	1 ☐ Never Married 2 🖾 Ma	rried 1	Yes 2 2 f Yes, Give			1 ☐ Yas			1 donto	riioari, otor,			GIO.	
14 Q	3 ☐ Widowed 4 ☐ Divorce	d	Year or Dates			10 143	2 (2)	оросну.			Spec	my.	Whit	e
tal Hygiene. d other than "natural; c event, ins Medical Exa Be Completed by	15. Decede (Specify only high	nt's Education	n molated)		16a. Deca	adant's Us	al Occu	pation during most	of worki	Ina	16b. Kind of	Business/In-	dustry	
3 5	Elemantary/Sacondary (0-12)		Collaga (1-4or	5+)				during most ( ad)						
or the			2		Нот	nemak	er				Own 1			
and Mental Hygiene.  s merked other than  aumatic event, the  To Be Comp		, Last)						18. Mother	's Name	(First, Middle	, Maiden Sum	ame)		
	Frank Seth Hu	rd						Rit	a L	eahy				
traumatic	19a. Informant's Name/Relation	ship (Type, I	Print) (hus	sband)	19b. Mail	ing Addres	s (Stree	t and Number	or Rura	al Route Numb	er, City or Tox	m, State, Zip	Code)	
127 rtr	William Dougla	s Davi	dson		3730	Car	liff	Road,	Che	vy Cha	se, MD	2081	5	
	20a. Method of Disposition		7.11	CO	metery, cre	osition (Namatory or	other pla	ice)	,	Date	20c. Locatio	n - City or To	own, Stat	te
int: If its	1 Burial 2 Cremation 4 Donation 5 Other (		oval from State		opol:	itan	Crem	atory	8	/18/98	Alexan	dria.	VA	
	21. Signature of Funeral Service	Ligantijee	0		2	2. Name a	nd Addr	ess of Facility	Fra	ancis J	. Coll:	ins Fu	inera	al
Departing imports any inju	1 × to. 1	152								iversit	y Blvd	. West	:	
	On Part Enter the disease	r complication	20'	ed the death				ring,		20901	rroet		Approx	Imate
	23a. Part T. Enter the disease, or heart failure. Lis	t only ona ca	ausa on aach	lina.						,		150	Interva	Between and Death
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THE R					as a conse							1		
in end ial-transit Examiner		b		metast								1		
end II-tra	Sequentially list conditions, if eny, leading to immediate	100		Due to (or	es e conse	equence of	):							
Durie Durie	Cause (Diseasa or Injury	c												
physician end is the burial-transit edical Examir	that initiated events rasulting in death) Last			Due to (or	es e conse	quence of	:							
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attendir Ifor use Clan/A														
d by the attendiateched for use	Part II. Other significent condit	ons contribu	iting to death	but not resul	ting In the	underlying	cause g	iven in Part I.		23b. Dld	tobacco use	contribute t	o the ca	use of dea
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igned by the signed be datached by Physic												1		
page 2 should b										24a. Was	en autopsy ormed?	94	veilable p	
has be									_			of	f death?	n of cause
page page										10	Yes 2 No	11	Yes	2 No
E 0 0	25. Was case referred to medic	al						26. Place	of Deat	h (Check only	one)			
	examiner?	Hosp	ital: 1 ☐ Inpat	ient 2 E	R/Outpatie	ent 3 C	OA OI	her: 4 Nur	sing Ho	me 5 Ras	idenca 6 🗆 (	Other (Speci	ity)	
er this neral of	27. Manner of Death		8a. Data of In	iury	28b. Time		28c. Inju			28d. Describe				10 4
atlo	1 Natural 5 Pand 2 Accident inves	ng igation	(Month, D	ay rear)	tnjury	М		Yes 2 N	lo					
rs efter death.  al Director: After t led in by the funera  Certification:	3 ☐ Suicide 6 ☐ Could deter	not be	8e. Place of Ir	njury - At hor	ne, farm, s	treet, facto	ry, office			28f. Location	Street and Nu	m <i>ber or Rur</i>	al Route	Number,
din t	4 Homicide		building, e	etc. (Specify)						City of 10	wn, State)			
24 hours efter Funeral Direction filled in filled in filled in filled in filled in filled in filled in filled in filled in filled in filled fi	29a. Certifier 1X Certify	ng Physicia	n: To the best	of my know	iedoe dea	th occurre	d at the t	ime, date and	nlaca	and due to the	cause(s) end	manner as r	stated.	
within 24 hours efter de To the Funeral Directo complately filled in by the Medical Certific	(Check only 2 Medica	Examiner:		of examination						ed at the time,				usa(s)
within 2 To the complain	29b. Signeture end title of certifi		arra mannat s	ated.		2	9c. Licen	se number			29d. Date sig	ned (Month	Dev. Ye	ear)
* F 8	N 1/C							0628	9					
V	17	MD					D>	-078			08	15/98	>	
	30. Name and address of person	who comple	ated causa of	daath (Item										
	Kevin Moo	- 4	0 86	10 00	2 ge	onget	D000	RD.	Be	tresda	MD 7	10814		
State	31. Date filed (Month, Day, Yea	1000	32. Pegis	trar's Signatu	re 4			,				,		
Dominton	(1111-11	MAN	4		had.	11/	1120 1	2/						



				Ce	ertificate	of De	ath			Reg. No		-	
1. Decedent's Nen	na (First, Middl	le, Last)							2. Data of D Month	aeth Da	v	Yeer	3. Time of Death
Ka	ite			Duymo	vic						1998		11:15AN
		n, give street end n				4b. 0			ocation of Dee	th 4c.	County	of Death	
Kockv  5. Social Security 1		ursing Ho	T	land hidhda	If Under 1	Voor If	Roc Undar 2	kvi]				omer	<i>A</i>
109-44-1		1 M 2 X F	7. Age (In yrs.	Yrs.			lours	Min.	(Month, D	ey, Year)		9. Birth	plece (Stete or Fore intry)
Usuai Residence d			83						Aug.	25, 1	1914	C	roatia
10a. Stete	10b. County		10c. Cit	y, Town or L	ocation								10d. Inside City Limi
Maryland	Montg	OTHO TEXT	Po	thesda									1 X Yes 2 1
10e. Street end Nu		omery	De	Luesua	10f. Zip Co	ode				10g. Cit	izen of V	Vhet Cou	intry?
5911 Wi	1mett 1	Road			208	17				-	S.A		,
11. Meritel Status		12. Was De	cedant Evar in U	.S. 13.			nic Orig	in? (Sp	ecify Yas or N	-		e · Amari	Icen Indien.
1 Navar Mari	ried 2 ☐ Marr	Armad F	orces?		Was Daceder If Yas, specify	y Cuban, N	faxicen,	Puerto	Rican, etc.)		Bled	k, White	, etc.
3 Widowed	4 Divorced	If Vac G	iva		1 ☐ Yas 2	No S	pecify:				Specify	· W	hite
	15. Deceden	it's Educetion		18e. Dece	edent's Usuel C	Occupation	1	71		16b. K	ind of Bu	ısiness/Ir	ndustry
(Specification)		st grada complated	(1-4or 5+)	(Give	e kind of work DO NOT use	done durir retired)	g most	of work	ing				
4		College		Ноп	emaker					Ow	n Ho	me	
17. Fether's Nema	(First, Middle,	Last)				18.	Mother	's Nem	e (First, Middle	e, <i>Meid</i> en	Sumem	re)	
Anton I	lijic						Luc	e Il	lijic				
19e. Informent's N	eme/Relations	ship (Type, Print)		19b. Meil	ing Address (S	Street end	Number	r or Run	al Route Num	ber, City o	or Town,	Stete, Zi	ip Code)
Andrew D	uymovi	c-Son		5911	Wilme	tt Rd	١., :	Beth	iesda,	MD 2	0817	,	
20e. Method of Dis			20b. P		osition (Neme amatory or other			1	Dete	T			own, Stete
1  Burial 2 4  Donation		3 ☐Removel from	Siaia		ove Ce		v	18	/19/98	Kow	Gard	lens	, New Yor
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To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit Division of Vital Records, P.O. Box 68760,

> State Registrar

Physician /Medical Examine

**Funeral** Director

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Heelth and Mentel Pyglene. Important: if itam 27 is marked other than "netural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner, must be notified at once.

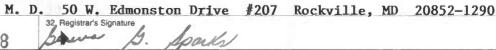
**Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0020

Brid

31. Dete filed (Month, Day, Year) AUG 1 8 1998

Paul T. Noone,

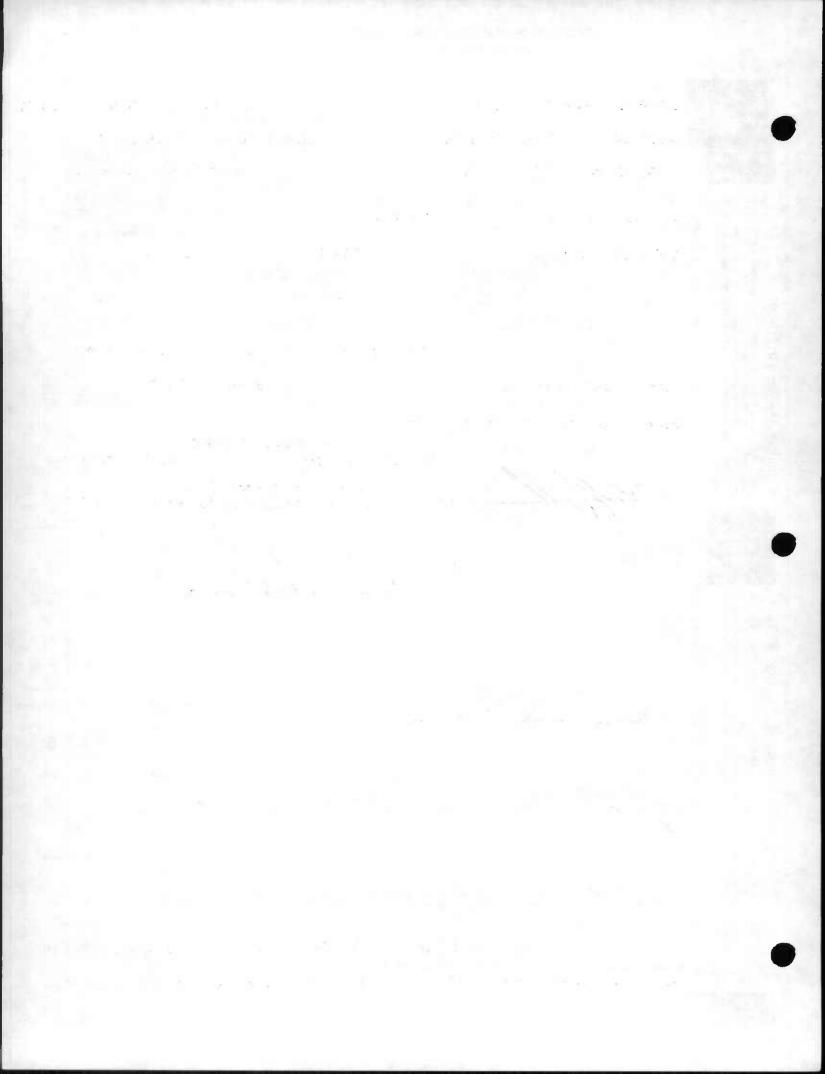


DHMH 16 Rev 6/95

The States reproduced a participation to the community of

# Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 8 267 6

		Certificate of Dea											
Physic	ian	1. Decedent's Name (First, Middle, Last)							Month Dey Yeer			3. Time of Death	
/Medi		LAWRENCE RUBERT DRINKARD							AUGUS!			11:55AM	
Exami	ner	4e Fecility Neme (If not institution, give street and number)							or Location of Dea		4c. County of Deeth		
		1036 EAST POTOMAC AVENUE  5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) If Under 1 Yes							V HEAD		CHARLES		
Funeral Director		5. Sociel Security Number 214–32–8247	7. Age (In yr	7. Age (In yrs. lest birthdey) If Under 1 Ye.  85 Yrs. Months Dey				Hours Min (Month, L		opy, Year) 9,1913  9. Birthplece (State Country) Missouri			
pug *		Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location								10d. Inside City Limits			
/anyle	0	Maryland Charles Indian Head										1)X Yes 2 □ No	
Dallimore, Maryland ZIZI3-00Z0 permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pygiena. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Exercise must be incidited and once.	ect	10e. Street end Number 10f. Zip Cod					Code			10g. Citizen of N	Whet Cour	ntry?	
	D						0640			U.S.A.			
	Be Completed by Funeral Director	11 Marital Status 12 Wes Decedent Ever in U.S. 13 Was Decedent of						dispanic Origin?	(Specify Yes or N	No- 14. Reca - American Indien,			
		Armed Forces? If Yes, specify Cub  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No  1 □ Yes 2 ☑ No  Yesr or Detes:					en, Mexican, Pu	Blee	Bleck, White, etc.  Specify: White				
		15. Decedent's Education 16e. Decedent's Usuel Occupetion (Specify only highest grede completed) (Give kind of work done during most of work								16b. Kind of B	usiness/in	dustry	
		(Specify only higher Elementery/Secondary (0-12)		College (1-4or 5+)			life. DO NOT use retired)		WOIKING				
		12				Chief Quarter			nanic	U.S. Govern		ment	
		17. Fether's Neme (First, Middle, Last)  18. Mother's Nar						Name (First, Midd	me (First, Middle, Malden Surneme)				
	To	Grover Cleveland Drinkard Myra En							Ennis Dr	nnis Drinkard			
		19a. Informent's Name/Relations	ship (Type, Print)		19b. Mei	ling Address	(Street	end Number of	r Rurel Route Num	ber, City or Town,	Stete, Zip	Code)	
		Mildred Lee Dri	nkard	Wife	Same	as #	10						
		20e. Method of Disposition	. CD		Place of Disp	osition (Nen	ne of ther pie	ce) Angus	at 21.199	20c. Location	City or To	own, Stete	
Peges nant of l		20b. Method of Disposition  1 \( \text{M Burial 2 \( \text{Donetion 5 \( \text{Other (Specify)} \)} \) 20b. Place of Disposition (Neme of cometery, cremetory or other place) \( \text{August 21,1998} \) 20c. Location - City or Town, Stele cometery, cremetory or other place) \( \text{August 21,1998} \) 4 \( \text{Donetion 5 \( \text{Other (Specify)} \)} \) Christ Episcopal Church \( \text{Wayside, Maryland} \)											
permit. F Departm Importar any injur		21. Signeture of Funerel Service	Censee		1	22. Name en	d Addre	ess of Fecility					
		Williams Funeral Home, P.A.											
		M00668 \$270 Hawthorne Rd., Indian Head, Md. 20640  23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.  WITHOUS Fulleral notice, F.A.  20640  Approximate Intervel Between Onset end Deeth											
Physician		Immediate Ceuse (Final											
/Medical													
Examiner		disease or condition resulting in death)  e. Carry Tue   Flexit   Cartue   Public (or on a consequence of ):											
	ē	Due to (or es e consequence of):											
ath certificate be executed attanding physician end	in in	Sequentially list conditions  b. Uthro Studelle   Pelus   Fridail  Due to (or es e consequenca of):											
	Examiner	if eny, leading to immediate cause. Enter Underlying											
fficate be ex	edicai	Cause (Disease or Injury C											
ificat g phy as th	be	resulting in deeth) Last											
ndindin use	M	d											
the death by the attar	by Physician	Dot II. Other elevidicent conditions contribution to death but not continue in the underlying and the second state of the seco								23b. Did tobacco use contribute to the cause of death?			
iras that the death censigned by the attanding be deteched for use	hys	Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.								1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown			
that hed be dete	y P									1 145 ZEINO OLITOBBIN VIOLINIONI			
uiras n sign	D D									24e. Was en eutopsy performed?		ere eutopsy findings reilable prior to	
ne law requiras to has been signe to go 2 should be	lete								pe:			ompletion of cause deeth?	
ysician: The law requiras that is certificete has been signed but director, page 2 should be detent	Completed								15	Yes 2 No		_ /	
		25. Wes case referred to medica											
OI VICAL Physician: T rithis certificel oral director, p	o Be	examiner?	Hospital:		T. 50.00		Ot	hor	Death (Check only			4.1	
this raidi	-	1 ☐ Yes 2 ☑ No  27. Menner of Deeth		1 Inpatient 2 EMOutpetient 3 DOA 4 Nursing Home 5 Emesidence 6 Dotner (Specify)								<i>TY)</i>	
To the Hospital or Attending Phy within 24 hours elfar deeth. To the Funeral Director: After this completely filled in by the funeral or a funeral completely filled in by the funeral or a function or a funeral or a function or	lon	1 DNeturel 5 □ Pending (Month, Dey Year) Injury Work?											
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury. At home farm street factory office							28f Location	28f. Location (Street and Number or Rural Route Number,			
	in.	4 ☐ Homicide determ	nined 200. Pi							City or Town, Stete)			
		200 Contine a 576-uta	- Dharleton To	the best of multi-		th annual	- A Ab - A:	ma data and a	loop, and due to the	an annual (a) and m		atatad	
	edicai		Examiner: On the	basis of exami					lece, end due to the occurred et the time				
	Med	one) end manner stated.  29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)										Dev. Year)	
		290. Signeture end title of certifier  1 Jun J. Bulle Ms 0001009							00	AUGUST 18, 1998			
)									7				
		30. Name end eddress of person					D 2	(/[]\/	ra nr	MA 145		0646	
		HENRY L. BUI				KANG	e A	VENUE,	LA PLA	ATA, MD	2	0646	
St Regist	ate	31. Dete filed (Month, Dey, Year,		Registrer's Sig		9 1	no.	Kal					
negist	i al	AUG Z	4 1998	1	/	. 100	DETA	15-70					

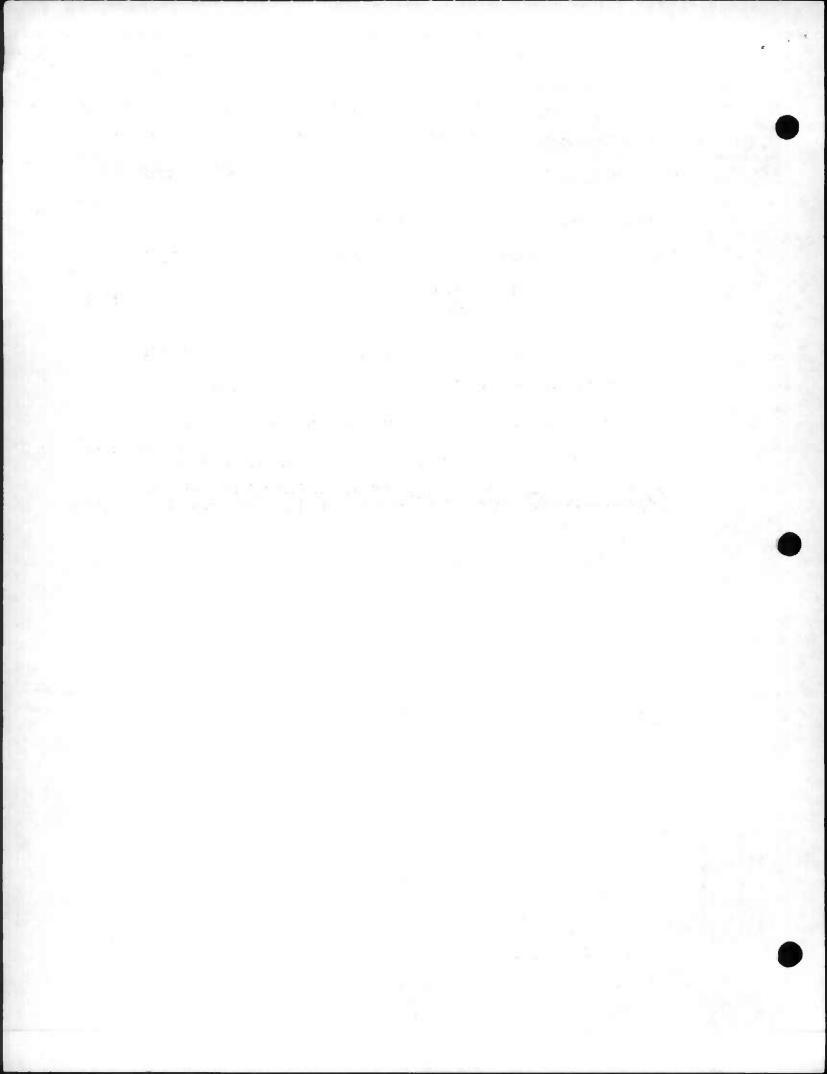


State of Maryland / Department of Health and Mental Hygiene 9 8 2 6 7 1 7

Certificate of Death

2. Dete of Deeth 3. Time of De

1. Decedent's Neme (First, Middle, Last)  Edward Clifford	DURELL Jr	2. Dete of Deeth Month Dey AUGUST 13 19	3. Time of Deeth
4a. Fecility Name (If not institution, give street end number) SHORE NURSING & REHABILITATI			
5. Social Security Number $185-05-8039 \ \ A \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $		n. (Month, Dey, Yeer)	Birthplece (State or Foreign Country) Penna.
	n or Location		10d. Inside City Limits
		10a Citizen of Mine	1 ☐ Yes 2 ♣ No
			Country
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married   12. Was Decedent Ever in U.S. Armed Forces?		(Specify Yes or No- erto Rican, etc.) 14. Race - A Bleck, V	Americen Indien, Vhite, etc.
100.00.000.111111	(Give kind of work done during most of w	16b. Kind of Busine	
Elementery/Secondery (0-12) College (1-4or 5+)		Building	
17. Father's Name (First, Middle, Last) Edward Clifford Durell Sr.	18. Mother's N	eme (First, Middle, Maiden Surneme)	
7 7 11			
20a. Method of Disposition 20b. Plece 0		Date 20c. Location - City	1663 v or Town, State
4 Donetion 5 Other (Specify) Whitem  21. Signature of Funerel Service Licensee	22. Name end Address of Facility	ery 8-19, 1998	ville, leime
Danceon E Leonard			21662
23a. Pert1. Enter the diseese, or complications that daused the death. Do shock, or heart failure. List only one ceuse on each line.	not enter the mode of dying, such es cerdi	ac or respiratory errest,	Approximete Intervel Between Onset end Death
Immediate Ceuse (Final disease or condition resulting in death)  e. Alz he was	mer's Dementie		VEG
	consequence of):		,
Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying	consequence of):		
	consequence of):		
d			
1		23b. Did tobacco usa contrib	oute to the cause of death Probably 4 Unknow
Diabetes Mellitus, Aspiration	theunania	-	tb. Were eutopsy findings
		performed?	aveileble prior to completion of ceuse of deeth?
25. Was case referred to medical			1 ☐ Yes 2 ☐ No
examiner?	Oil .		Specify)
1- Naturel 5 □ Pending (Month, Dey Year)   1 2 □ Accident Investigation	Time of 28c. Injury et	28d. Describe how injury occurred	
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street end Number o. City or Town, Stete)	r Rural Route Number,
29a. Certifier (Check only one)  Certifying Phyelclen: To the best of my knowledge 2 Medical Examiner: On the basis of examination en and manner stated.	e, death occurred et the time, dete end ple id/or Investigation, In my opinion, death occ	ce, end due to the ceuse(s) end menne curred et the time, date and place, and	r es steted. due to the ceuse(s)
29b. Signature and talk of peopling	29c. License number	29d. Date signed (M	lonth, Dey, Year)
( ) CARY ( DV)			198
30. Name and address of person who completed cause of death (Item 23e) Po Bot 122, Golds Some, MI)	(Type, Print) Jeffrey Dont	en, ms	
	4a. Fecility Name (If not institution, give street end number) SHORE NURSING & REHABILITATI  5. Social Security Number 185-05-8039 A  Usuel Residence of Decedent 10e. State 10e. State 10e. Street and Number 23820 Mt. Pleasant Landing Rd.  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) 17. Father's Name (First, Middle, Last) 18. Informent's Name/Relationship (Type, Print) 19. Jean Bailey Durell Wife 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Licensee  22a. Pert 1. Enter the disease, or complications that daused the death. Do shock, or heart failure. List only one ceuse on each line.  Sequentially list conditions, if eny, leading to immediate Ceuse (Final disease or condition resulting in death)  Pert II. Other significant conditions contributing to deeth but not resulting in death)  Pert III. Other significant conditions contributing to deeth but not resulting in leath)  Pert III. Other significant conditions contributing to deeth but not resulting in leath)  25. Wes case referred to medical examiner?  1 Yes 2 Pop 1 Due to (or as a determined)  25. Wes case referred to medical examiner?  1 Yes 2 Pop 1 Due to (or as a determined)  25. Wes case referred to medical examiner?  26. Due to (or as a determined)  27. Manger of Deeth (Predictions on the best of my knowledge (Rock only Could not be determined)  28. Date of Injury. At home, factor only conditions and manner stated. Specify and manner stated.  29. Signature and the determined and manner stated. Specify and manner stated.	46. Fecility Name (If not institution, give street and number) SHORE NURSING & REHABILITATION CTR.  5. Social Security Number 185-05-8039 A	S. Slocial Security Number  185-05-8039 A  180 20 P  7. Ape (In yr. s. act birmship)  100. City, Town or Location of Death  185-05-8039 A  180 20 P  7. Ape (In yr. s. act birmship)  100. City, Town or Location  100. Special Security Number  100. Special Security Number  100. County  100. City, Town or Location  100. City, Town or Loc



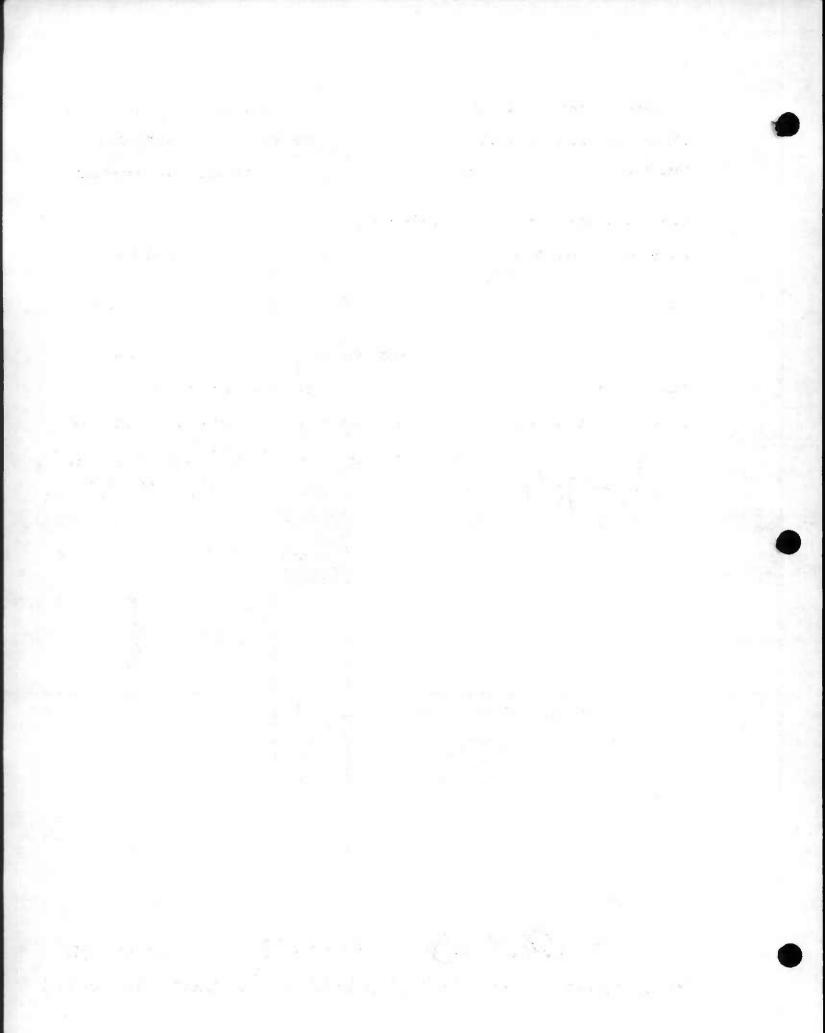
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Yaar 4b. City, Town, or Location of Daath 5:20 Am MAE FLEMING 16, 1998 /Medical 4a. Facility Nama (If not institution, give street and number) 4c. County of Daath Examiner BROOKE GROVE NURSING CENTER **OLNEY** MONTGOMERY 5. Social Sacurity Number If Undar 24 Hrs. if Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yes Birthplaca (Stata or Foraign Country) **Funeral** Days Hours 1□M 2□F Yrs. 225-09-8555 87 Director Apr 13, Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at the Maryta 1 ☐ Yas 2 ☐ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15029 Joshua Tree Road 20878 United States 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify 3 ☑ Widowed 4 □ Divorced white Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Bank Teller Banking Pages 1 and 2 should be filed vinent of Health and Mental Hygister; if Nem 27 is marked other 1 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Oscar Bura11 Ida Mae Angleberger 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health as Important: If them 27 is any Injury or other trac once. C. Wayne Fleming, 15029 Joshua Tree Road, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 Burial 24 Cremation 3 Removal from State
4 Doyal on 5 Other (Specify) Aug. 17 Metropolitan Crematory 11998 Alexandria, Virginia 21. Signature of Funeral Service License 22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877 Enter the dispara, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** PNEUMONIA /Medical Immediata Cause (Final 6 DAYS disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? RHEUMATICA 1 Yes 2 No 3 Probably 4 Unknown p Be Completed 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s certificate 1 🗆 Yas 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only ona) 1 Yas 2 No Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Waturai 5 Panding 1 ∏Yes 2 ∏No Invastigation 2 Accidant 3 Sulcida 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at tha time, dete end place, and due to the ceuse(s) end mennar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred et the time, deta end place, and due to the causa(s) end mannar stated. edicai 29a. Certifier 29b. Signatura and titla of certifier ... 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) Overlook Br. Boonsboro, MD 21713

32. Registrar's Signatura

State Registrar



State of Maryland / Department of Health and Mental Hygiene ( Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUG U ST FURIANC **Physician** RAZIANE 0020 A /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOSPITAL SHADY GROVE ADVENTIST MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) **Funeral** Months Deys Hours 1⊠M 2□ F Yrs. 83 Director 579-10-2882 April 19, 1915 New Jersey Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner nast be notified at To Yes 2 □ No Director Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with permit. Pages 1 and 2 should be filed within 72 hours after deeth v
Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or items 23a
any Injury or other traumatic event, the Medical Examples 2000. 4701 Aspen Hill Road 20853 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-45 1 ☐ Never Married 2 T Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Service Station Proprietor Automobile 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Guisseppe Furlano Elizabeta Danielli 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Patricia F. Voitk (daughter) 22100 Creekview Drive, Gaithersburg, MD 20882 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 8/24/98 Silver Spring, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 Univeristy Blvd. West Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** BLADDER GARCINOMA Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examiner physician and the burief-transit The law requires that the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequença of): P.O. Box 68760 Physician/Medicai Due to (or as e consequence of) usa for signed by the e 23b. Did tobecco use contribute to the cause of deeth? Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. Nes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy performed? Completed (BONIC OBSTRUCTURE DUCHONORY DUCHONORY DUCHOSE completion of cause of deeth? certificata has t lirector, paga 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 1 Inpetient 2 □ ER/Outpetient 3 □ DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 28a. Date of Injury (Month, Dev Year) 5 Pending 1 Natural 2 No death. 1 Yes Investigation by the 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) s 24 hours after d be Funeral Direct pletely fillad in by 4 Homicide edical 29a. Certifier 🕍 Certifying Phyelclen: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) end menner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pieca, end due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29th Signifure end title of certifier 20 and address of person who completed cause of deeth (Item 23e) (Type, Print)

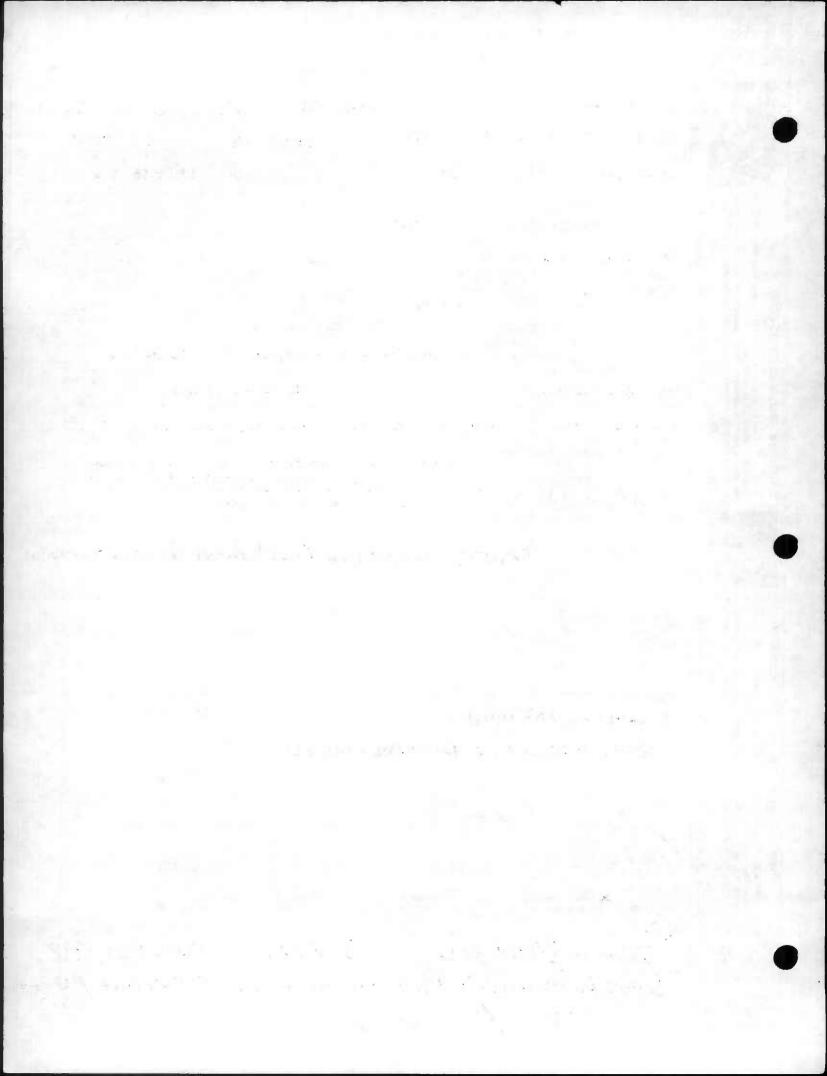
A BROWN WI) 9707 M4 707 MEDICAL CENTER DRIVE, 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

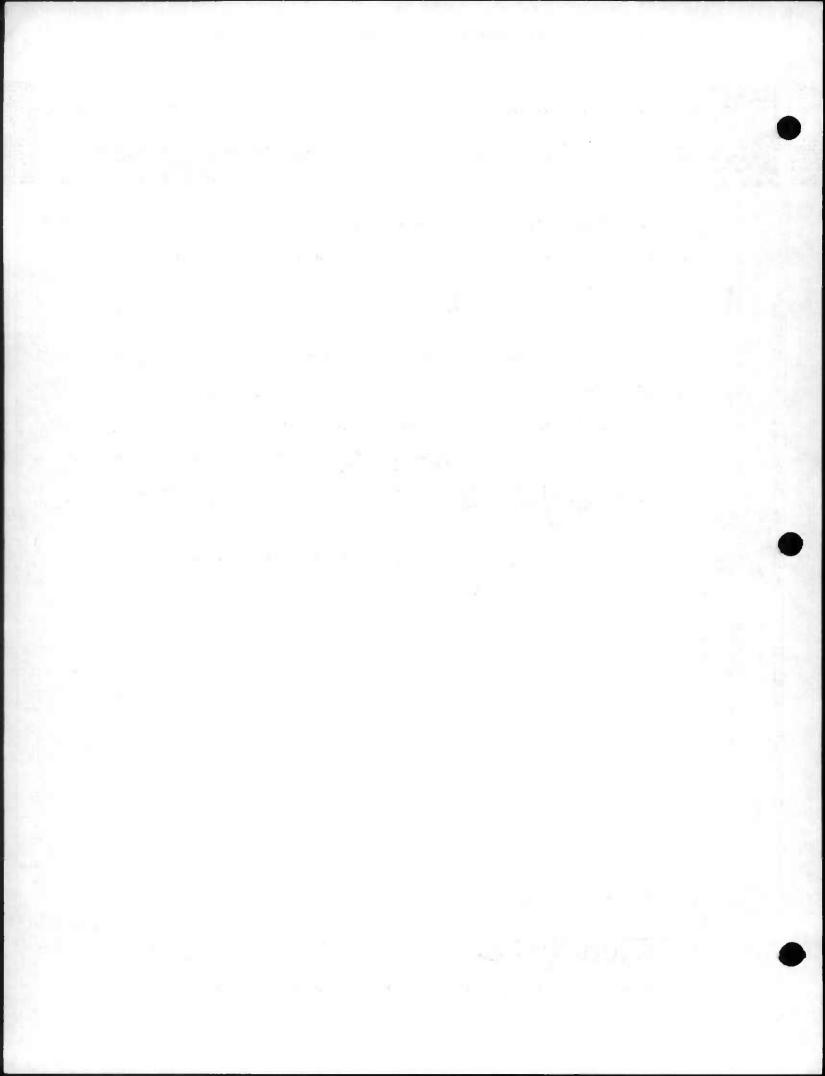
Registrar

AUG 21



State of Maryland / Department of Health and Mental Hygiene 96720

Sepantians that the death certificate be executed  The death certificate be executed by the attention of the death certificate be executed by the attention of the death certificate become and the death certificate because the death	sual Residence of Decedent De. State 10b. County  (aryland Montgo De. Street end Number  0017 Quinby Str  1. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's (Specify only highest structure)  7. Fether's Neme (First, Middle, Later of Structure) Dohn T. Gilmore De. Informent's Neme/Reletionship Eloise M. Gilm De. Method of Disposition 1 Marital Stetus  1 Signature of Funeral Service Lie  3 Party Enter the disease, or both of the or heart failure. List on	Gilmore give street end number)  ital  Sex  1 SM 2 F 71  10c. Cit  mery S  12. Wes Decedent Ever in U  Armed Forces? WWI  1 SYes 2 P 944  Year or Detes: 1944  Education grade completed)  College (1-4or 5+)  5+  10c. Cit  Mery Sive 1944  Year or Detes: 1944  College (1-4or 5+)  5+  SERemovel from State city)  Consee	ty, Town or Location  Silver Spr  100  Silver Spr  100  Silver Spr  100  Silver Spr  100  If Yes,  Give kind of life. DO No  Register  19b. Meiling Add  10017 Que  Place of Disposition  22. Nam  France  500 U	ring M. Zip Code  20 Decedent of His specify Cubar fees 2 No  Usual Occupa of work done do OT use retired)  red Arc  dress (Street e  linby S (Nome of y or other plece Presbyt etery ne end Address	chitect 18. Mother's Nem Claric end Number or Rur Street S ee) terian	2. Dete of Deeth Month Aug. 16 ocation of Deeth ring 8. Dete of Birth (Month, Dey, Jan. 14,  10 ecity Yes or No- Ricen, etc.)  11 ecity Yes or No- Ricen, etc.)  12 ecity Yes or No- Ricen, etc.)  13 ecity Yes or No- Ricen, etc.)  14 exists Middle, Me Way el Route Number, 11 exists Sp Dete 2	Dey , 1998  4c. County of Mont (Year)  1927 Was (1927)  1927 Was (1927)  1928 Mont (Year)  1928 Mont (Year)  1928 Mont (Year)  1928 Mont (Year)  1929 Mont (Year)  1929 Mont (Year)  1929 Mont (Year)  1920 Mont (	gomery  9. Birthplece (State of Country)  ashington,  10d. Inside Ci 1  Yes  het Country?  - American Indian, , White, etc.  White inness/Industry  / Design  State, Zip Code)  ryland 209
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1 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		aminer: On the basis of exemina end menner steted.		29c. License		29	d. Date signed (	(Month, Day, Yeer)
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1041	(Check only 2 Medicel Expone)	end menner steted.		1519	1-1	A	ug,17,19	998
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	(Check only 2 Medicel Excore)  b. Signeture end title of certifier  Name end eddress of person who	end menner steted.	, , , , ,					
State 31. Registrar	(Check only 2 Medicel Exc	end menner stated.	ckville I					



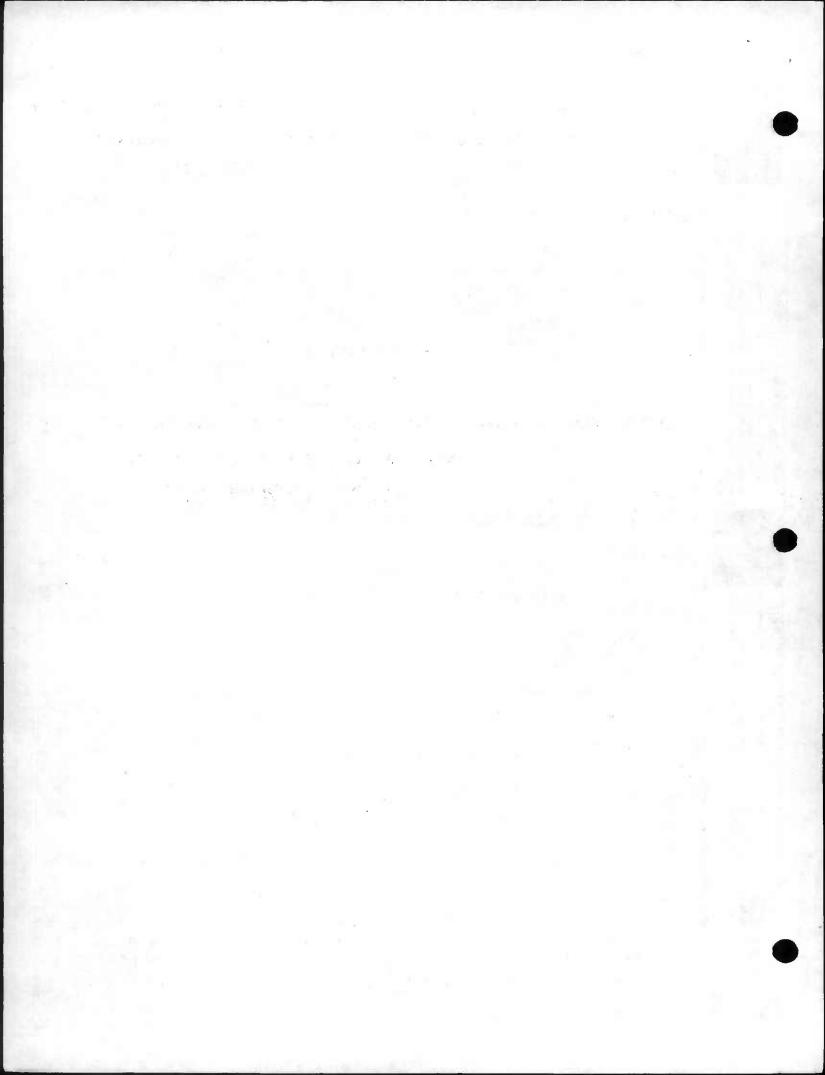
_	_	AUG 1 2 1000		Cei	tificate of	Death		Reg. No.	2.0	61
Phy	ysician	Decedent's Name (First, Middle, Last     RAYMOND GEORGE	GARNER				2. Date of De Month AUGUST	Day	Year	ime of Death L:47 AM
<b>1</b>	ledical	4a Facility Name (If not institution, give				4b. City, Town, or I		-		1:4/ AM
EX	aminer	FREDERICK MEMORI				FREDERIC		,	DERICK	
Fun Direc		Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	and the second second	th	9. Birthplace (	State or Foreign
ъ.		Usual Residence of Decedent	T <sub>10</sub> or							
aryla	4	MARYLAND FREDER		y, Town or Lo REDERIC						Side City Limits  Yes 2000
with the Maryland a or 28s-f show	Director	10e. Street and Number	-CK PF	CEDEKIC	10f. Zip Code			10g. Citizen of \		Z 100 AFV.
1 0 a		7093 GRESHAM COUR	RT WEST		2170	3		UNITED		
death ma 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	,S. 13. \	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No	- 14. Rac	e - American Inc	lian,
UZU nurs after aif, or its	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give WW ☐ Year or Dates:		Yes, specify Cub		o Hican, etc.)	Specify	ck, White, etc.  V: WHIT	Ξ
2 5 M	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	lent's Usual Occup	pation during most of wor	kina	16b. Kind of B	usiness/Industry	10.376
N SH	a de	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)		CCDAD	TDON C N	ATOM A T
A pare		17. Father's Name (First, Middle, Last)		SELF-	EMPLOYED	(RETAIL)			IRON & N	1ETAL
and be	0 8	LEO GARNER					BRENNER	Maioen Cornari	110)	
Ta Man	F	19a. tnformant's Name/Reletionship (T)	rpe, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip Code	)
M Page		MICHAEL GARNER	(SON)	1213	MARRIOTT	SVILLE RI	MARRI	OTTSVIL	LE, MD.	21104
E 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	6	20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	Ţ	Date		- City or Town, S	
Pag Hitt	0	1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify)	ternoval from State		AEL CONG		/10/98	OXON I	HILL, MA	RYLAND
sail.	N N	21. Signature of Funeral Service Licens	96		Name and Addre		MEMORIA	I CHARE	IC INC	
u aos	8 8	James Den	lon	11	70 ROCKV	GOLDBERG	E-ROCKVI	LLE, MA		
		23a. Part . Enter the disease, or compl shock, or heart failure. List only or	ications thet caused the deat ne cause on each line.	h. Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,	Inten	oximate val Between ot and Death
Physic /Medi		Immediate Cause (Final							Orise	and Deam
Exami		disease or condition resulting in death)	SEPSIS						8 H	DURS
	<b>1</b>		BACTERIAL	TNEECT					12.1	HOURS
cete be executed physicien and	Examine	Sequentially list conditions	). ————	r as a conseq					112 1	100K5
5 6		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			30.100 0.7.					
filcete be ex physicien	edical	that initiated events resulting in death) Last	Due to (o	r as a conseq	uence of):					
certificet certificet ading phy										
0 5 8	Physician/M								1	
t & &	rysic	Part It. Other significant conditions cor	tributing to death but not res	ulting in the ur	nderlying cause gr	ven in Part I.	1000		ntribute to the o	
T d d	by Pt	END STAGE RENAL	DISEASE				10	Yes 2 No	3 ☐ Probably	4 Unknown
v requires that the de		HYPOGLYCEMIA					24a. Was	an autopsy	24b. Were au available	topsy findings
D & S	Completed	HITOGLICENIA					pend	rmed?	completi of death	on of cause
The level of the hear	Com						10	Yes 2 No	1 ☐ Yes	2 No
vital sicien: The certificate	Be C	25. Was case referred to medical examiner?				26. Place of Dec	th (Check only o	one)		
- 5 9	5	1  Yes 2 No		ER/Outpatien	1 3LI DOV		ome 5 Resi	dence 6 Oth	ner (Specify)	
After t	tlon:	27. Manner of Death 1 ⊠Neturel 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occur	rred	
Attending or deeth.	tificat	2 Accident investigation 3 Suicide 6 Could not be	One Pleas of lains. At he			Yes 2□No	29f Location /	Street and Numb	ber or Rural Rou	to Alumbar
or Attended the charter	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)	set, lactory, office		City or To	en, State)	on or mararmour	e reamber,
To the Hospital or J Within 24 hours efter To the Funeral Dire	0	29a. Certifier 1 X Certifying Phys	sician: To the best of my kno	wledge, death	occurred at the ti	me, date and place	, and due to the	cause(s) and me	enner es stated.	
Me Ho	edical		ner: On the basis of examina and manner stated.							ause(s)
To th	N N	29b. Signature and title of certifier		0	29c. Licens			29d. Date signe	d (Month, Day,	(ear)
8		Mellell	140	/	D29	591		8/101	91	
	SVIII I	30. Name and address of person who co				WE	DEDT CT	MADUT	D 01700	
		MARK P. RUBIN,	TID - ZUI THUN	TAD JUH	MOON DKI	VE - FKE	JEKIUK,	PLAKILAN	n 71/07	

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) AUG 1 8 1998

Spark

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

				Cei	uncate o	Dealli		Reg. No.		
cian dical		M. 6		EZ			2. Dete of De Month	Dey 19	Yeer 98	3. Time of Death
5. Social Security 540-1	HOLY CROS rity Number 4-9442	6. Sex	L	s. lest birthday) Yrs.	If Under 1 Yes	SILVER	Min. (Month, De	M	ONTG( 9. Birthp Cour	OMERY blece (State or Foreign try) OREGON
10e. Stete	ca of Decedent 10b. County		100 (	City, Town or Lo	nation				-	0d. inside City Limits
MD.		COMERY	100. 0		R SPRIN	G				1 XYes 2 No
10e. Street en	d Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
270	OO BARKE	ER ST.				20910		U	.S.A.	
	tus Married 2□ Marr ed 4□ Divorced	It Yes Giv	rces? 2 🕅 No /e		Ves Decedent of Yes, specify Co □ Yes 2\vec{1}{2}\vec{1}{2}\vec{1}{2}\vec{1}{2}		n? (Specify Yes or No Puerto Rican, etc.)	Specify	ck, White,	can Indien, etc.
-110	15. Deceden	it's Education		16a. Deced	ent's Usual Occ	upation		16b. Kind ot B	usiness/In	dustry
	Specify only higher Secondary (0-12)	st grede completed) Collaga (1	1-4or 5+)	(Give	kind of work dor OO NOT usa rati	ne during most of ired)	of working			
ĺ					HOUSEWI	FE		AT	HON	Œ
7. Fether's No	eme (First, Middle,					18. Mother	's Neme (First, Middle	, Meiden Suman	ne)	
	ROEY	SI	OCUM				MAE MY	RTLE W	INCH	ELL
19a. Informani	's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Stre	et and Number	or Rural Route Numb	per, City or Town,	State, Zip	Code)
ANNE G.	ABRIEL JA	ANNEY/DAUG		1801		ET DR.#	102, GERM			
20e. Method of	,	3 Removal from		Placa of Dispo cemetery, cren	sition (Neme of netory or other p	olece)	Date	20c. Location	- City or To	own, State
	ion 5 Other (S			HAMBERS	CREMAT	ORY	8/18/98	RIVER	DALE	MD.
21. Signeture	of Funeral Service	ambeur	Q <sub>MOOO</sub>		Neme end Add		L HOMES P	A. SIL	VER S	20910 SPRING, MD
Immediate Ca disease or cor rasulting in da Sequantially li if eny, leeding cause. Enter Ceusa (Diseas that initiated er resulting in de	st conditions, to immedieta Jnderlying se or injury vents	e b c	Due to	(or es e conseq (or es e conseq (or as e conseq		un	Pre			Onset and Deeth
art II. Other s	ignificant condition	ons contributing to de				-		l tobacco use co		o the cause of death?
Cur	one 0	6 thul	tel	pull	pores	asses	2	1103 20110	т	
		7-11-1	-		/		24a. Wes	s en eutopsy ormed?	64	ere autopsy findings vailable prior to empletion of cause deeth?
							10	Yes 20 No	11	☐Yes 2☐No
25. Was case	reterred to medice					26. Plece	of Death (Check only	ona)		
axaminar? 1 ☐ Yes	210 NO	Hospitel:	npatient 2	☐ ER/Outpetien	t 3D DOA	Other:	sing Home 5 Res		ner (Speci	fy)
27. Mannar of Natura 2 Accide	I 5 Pendin	28a. Deta (Mont) gation	of Injury th, Dey Year)	28b. Tima of Injury	28c. Ir		28d. Describe	how Injury occur		
3 ☐ Suicid 4 ☐ Homic	datam		ot Injury - At ng, etc. (Spec	home, farm, str city)	eet, tectory, offic	Xe	28t. Location City or To	(Street end Numi own, Steta)	ber or Run	al Route Number,
29a. Certifier (Check onlone)	1 Certifyin 2 Medical	Examiner: On the be	bast of my kr ests of examir ner stated.	nowladga, daath nation end/or Inv	occurred et the restigation, in m	tima, dete end y opinion, deeth	plece, end due to the a occurred et the time	cause(s) and m , dete end place,	annar es s end due t	steted. o the ceuse(s)
29b. Signature	end title ot certifie	100			29c. Lice	ense number		29d. Dete signe	d (Month,	Dey, Year)
1. M	horas o	L' dent		KIN	ma	674		8/16/	98	
30. Name end	eddress of person	who completed caus	a ot death (Ite	em 23e) (Type,	Print)	230 WK	9 SHOR	de ite	01	20
31. Date tiled	Month, Day, Year)	1998 32.7	egistrer's Sig	nature $\mathcal{G}$	Some	61				

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ALEGORE: DIVENS DEFERENCE OF STR

29a. Certifier (Check only one)

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Important: If Item 27 is marked other then "netural", or Items 23e or 28e-1 show

Physician /Medical

**Examiner** 

Be Completed by Physician/Medical Examiner

Medical Certification: To

eny injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Plea	ase Type	or Print in	Black In	delible	e Ink.	. Assur	re Al	I Copies	s Are	Legi	ible.		
		e of Maryla	and / Depa		t of H	lealth ar		lental Hy		e9 8	2	672	23
1. Decedent's Neme (First, Middl	le, Last)			1111				2. Dete of De Month		Dey	Yeer	3. Tim	ne of Deeth
Chester Law	rence	Grabare	k			4h City, Tow	wn or Lo	August	st 19		998		15 A.M.
					1				"				
Franklin Woods 5. Sociel Security Number 015_14_5216	S Nursir 6. Sex 128 M 20	7. Age (In yr	rs. lest birthday) O Yrs.	) If Under Months		Baltin If Under 24 Hours	24 Hrs. Min.	8. Date of Bir (Month, De		ır)	Cour	plece (Ste intry)	ete or Foreign
015–14–5216 Usuel Residence of Decedent		78	3					Feb. 7	, 19	920	Mass	•	
10a. Stete 10b. County		10c. (	City, Town or Lo								1		le City Limits
	arford		Abero	1	- 4,				10- 0	The second			
10e. Street end Number 508 W. Bel Air	r Avenue	е		10f. Zip	1001					J.S.A	Whet Cour	ntry7	
11. Merital Stetus  1 ☐ Never Married 2 ☒ Marr  3 ☐ Widowed 4 ☐ Divorced	rried 1 🔯 Y	Decedent Ever in ed Forces? Yes 2 No es, Give WWI]		Was Deced If Yes, spec 1 ☐ Yes 2	cify Cube	Hispenic Original Mexican, Mexican, Specify:	in? (Spe Puerto f	ecify Yes or No Rican, etc.)	T	14. Rac	ce - Americ eck, White,	, etc.	1,
	nt's Educetion			dent's Usue	al Occup	petion during most o	of worki	ing	16b.	Kind of B	Business/In		
Elementery/Secondary (0-12) 12	College 6	ege (1-4or 5+) 6	The second second			gineer			U.	s. c	Govern	nment	t.
17. Fether's Neme (First, Middle, Lawrence Gr						18. Mother	r's Name	e (First, Middle )kraska	le, Maide				
19a. Informent's Neme/Relations Elizabeth C. ( 20e. Method of Disposition  ↑ Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (S	Grabarek	k (Spouse		8 W. I	Bel in me of other plea	Air Av	ve.,	Aberde Date	een,	MD Location -	2100 - City or To	01 Town, Stete	е
21. Signature of Funeral Service  Luston H  23e. Pert1. Enter the disease, or shock, or heert failure. List	Mus U	trales	spel At	2. Neme en arring berdee	nd Addres g-Cai	ess of Fecility irgo Fu Maryla	unera	al Home 21001-	e, P	P.A.		Approxi	imete Between
Immediate Ceuse (Final disease or condition resulting in deeth)	e	Preuma	,									Onset e	and Deeth
	b	CVA										1 4	er
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury		Due to	o (or es e consec	quence of):								0	
Ceuse (Disease or Injury that initieted events resulting in death) Lest	C.	Due to	(or es e conseq	quence of):									
	d										1		
Pert fl. Other significant condition	ons contributing	to death but not re	esulting in the u	inderlying c	euse giv	ren in Pert f.			d tobecc				use of death?
									1160	2000	-	Automotive y	
F Cont								24e. Wes	es en eute formed?		ev cc	Vere eutop vailable pr completion of deeth?	
	- <u>'</u>							10	Yes :	2.2No		☐ Yes	2 No
25. Wes case referred to medice examiner?					1 24		of Death	h (Check only	one)				
1 Yes 2 No	Hospital:	1 ☐ Inpatient 2	ER/Outpetier		UA		rsing Hor	ome 5□Res	sidence	6 □Ot	her (Spec	ify)	
27. Manner of Death 1 ☑ Neturel 5 ☐ Pendir 2 ☐ Accident investi		Dete of Injury (Month, Dey Year)	28b. Time o Injury	of 2	28c. Injun Wor 1 🗌	nyat ork? ]Yes 2 □ N		28d. Describe	how inj	ury occur	rred		
3 Suicide 6 Could determ	not be nined 28e. F	Place of Injury - At building, etc. (Spe	t home, farm, st	reet, factory	y, office		1	28f. Location ( City or To	(Street e	end Numi	ber or Rur	el Route l	Vum <i>ber,</i>

To the Hospital or Attending Physician: The law requires that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29b. Signature end title of certifier 29c. License number

29d. Date signed (Month, Dey, Year)

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Baltimon

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

tontang
32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 1998 5:20 A.M August DORIS A. GORE /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) **Examiner** Franklin Square Hospital Ce.
5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Baltimore Center Rosedale If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (Stete or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 X X Yrs. 62 225-44-7389 Director 11/21/35 Virginia Usuel Residence of Decedent the Marylend 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Florida Volusia Director Oak Hill 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 121 Canal Avenue 32759 USA Funeral 72 hours after death 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 TVNo tf Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes XXNo Specify: SpecifWhite þ 3 ☐ Widowed ★ Divorced Completed Pages 1 and 2 should be filed within 72 ho nant of Health and Mental Hygiena. snt; If Item 27 is marked other than "natur ury or other traumatic event, the Medical 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home health care worker 12 Home Health Care 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be C. Raymond Overbay Margretta Croy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John M. Gore- son 1525 6th Way NW, Birmingham, ALA 35215

20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location - City or Town, State 20e. Method of Disposition Important; If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vernon Cemetery 8/18/98 Whiteford, MD 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Harkins F.H.Inc., 600 Main St., Delta, PA Phin1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Elevated 14 Hours emperature Examiner Examine Sepsis physician end s the buriel-trensit The law requires that the death certificeta be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) as 1 ettending p for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? ad by the datached signed by t 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy peed completion of cause of death? ate has bage 2 s Kartageners Syndrome
25. Wes case reterred to medical exeminer? 2 A No 1 Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician; director, Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After t 5 Pending investigation 1 Natural 124 hours efter death.

Per Funeral Director: Aft pletely filled in by the fur 1 TYes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.

Medicat Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner stated. edical 29e. Certifier completely (Check only one) within 2 29b. Signature and tille of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, Maryland 21237 Dr Geo-Philips hacko 82. Registrer's Signetur 31. Dete tiled (Month, Dey, Year) State AUG 17 1998

**DHMH 16 Rev 6/95** 

Registrar

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State of Maryland / Department of Health and Mental Hygiene

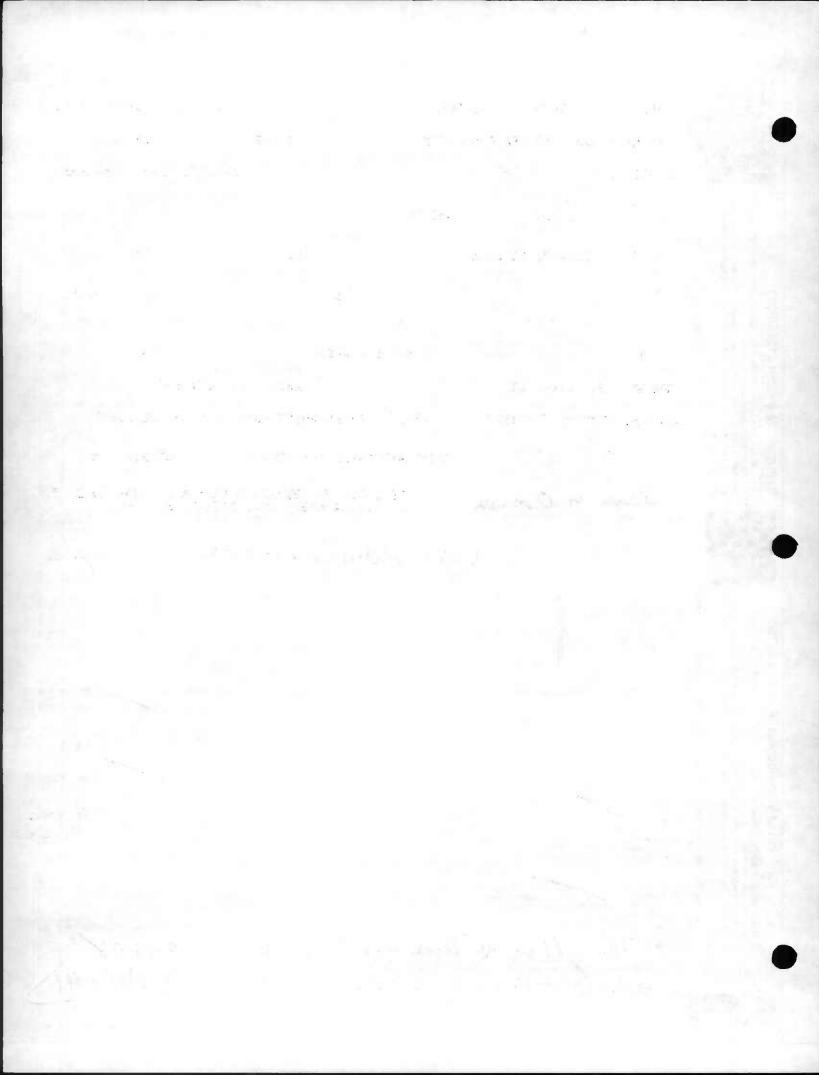
Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** 19 1998 8:20 AM AUG. EDEN GILLELAN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner HOSPICE HOUSE ,586 CYNWOOD DRIVE EASTON TALBOT 8. Date of Birth (Month, Dey, Yeer) APR. 27, 1949 if Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 9. Birthplece (State or Foreign 7. Age (In yrs. lest birthday) **Funeral** Months Deys Hours Min 1 M 2 TYF MARYLAND 49 Yrs. Director 217-78-5715 Usual Residence of Decedent with the Maryland 10a Steta 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiena. Int. If them 27 is marked other than "natural", or itams 23a or 28a-1 show ary or other traumatic event, I'm Medical Examiner from the north of all 1 ☐ Yes 2 No MD TALBOT EASTON Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 27825 B CEDAR POINT ROAD 21601 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ ∑No ff Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 X Never Married 2 Married 1 Yes 2 XNo Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) NEVER WORKED N/A-0-8 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be ANNE STINSON GILLELAN Μ. **GEORGE** Η. 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) 27825 B CEDAR POINT ROAD, EASTON, MD 21601 ANNE M. STINSON / MOTHER Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ACremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or CHESAPEAKE CREMATION CTR. 8-20-98 CHESTER, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21 Signeture of Funeral Service Licensee 22 Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) denocarcinoma vears 010 Examiner Due to (or es e consequence of) Examiner tha daath certificata be axecuted physician and the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): attending pl signed by the a d be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings eveitable prior to completion of cause of death? Completed 24a. Wes en eutopsy page 2 has 1 Yes 2410 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director. Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) HOSPICE 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Dea 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? Aftar Hous 5 Pending investigation 1 Natural after death. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) illed in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner as stated.

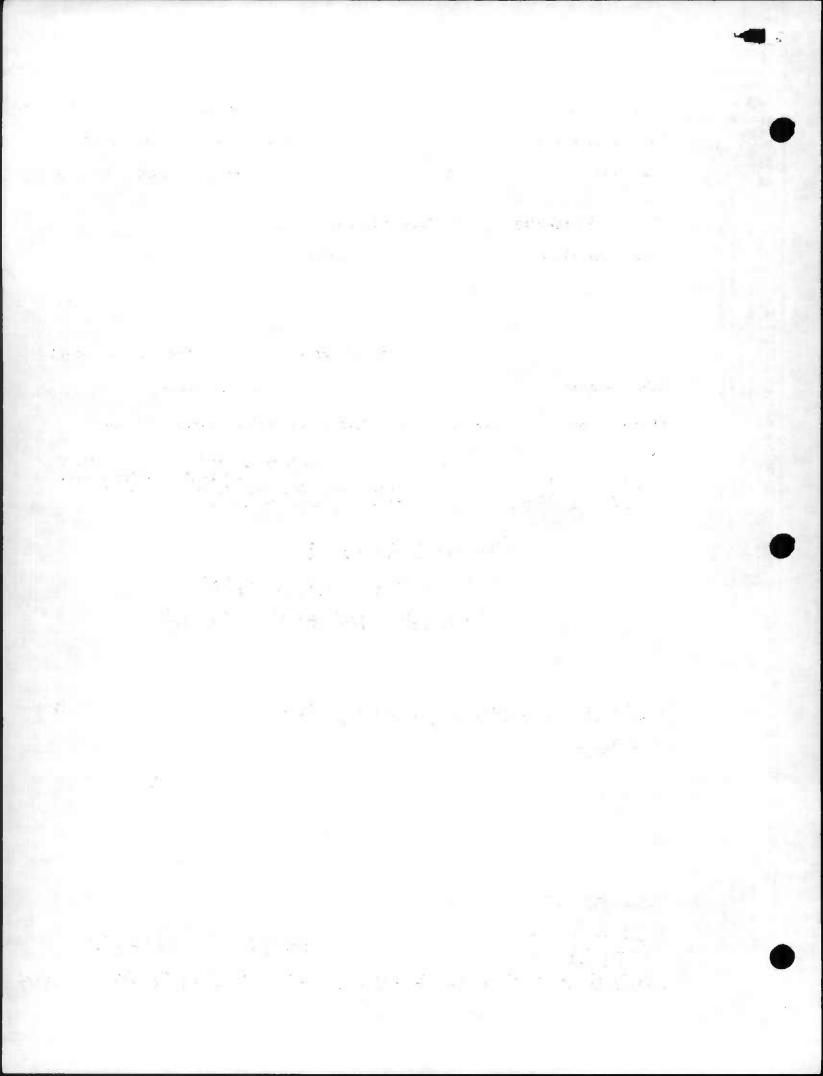
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated. To the Hosp within 24 hou To the Funer completely fil 29e. Certifier edicai 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dev. Yeer) 30. Neme end eddress of p ed cause of deeth, (Item 23e) (Type, Print) Mary Ann mbridge 31. Date filed (Month, Dey, 32. Registrer's Agneture State Registrar AUG 2 0 1998

DHMH 16 Rev 6/95



	1. Decedent's Neme (Fir		ont. Cty.	per M	Certi	ficate of	Death		2. Dete of Dee	leg. No.		3. Time of Death
Physician	Robert	E.	Hugh	AC					Month Lugust	Dey	Yeer 998	12:30 AM
/Medical Examiner	4e Fecilify Neme (If not						4b. City, To		afion of Deeth	-		12.30 11
LXummer	9500 Boye	r Plac	e				Silv	er Sp	ring	Mor	tgome	ery
Funeral Director	5. Sociel Security Number 014-16-57		Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I		If Under 1 Year Months Deys			8. Dete of Birth (Month, Dey			ce (State or Foreign y)
	Usual Residence of Dec	edant						]	reb. Z	1, 1920		sachusetts
ohow a		o. County			, Town or Loca						10	d. Inside City Limits  1 ☐ Yes 2 ☒ No
r tiems 23a or 28a-f show direct count be notified at Funeral Director	MD 10e. Street end Number	Montgo	omery		Silver	Spring 10f. Zip Code				10g. Citizen of V	Vhaf Counfi	
23a or marbe rai Dir	9500 Boye		e			209	10			USA		,
uner	11. Marifei Sfafus		12. Was Decede			s Decedent of es, specify Cul	Hispanic Or	rigin? (Spec	cify Yes or No-	14. Rece	- America k, White, e	
þ	1 Never Married 3 Widowed 4		1 Yes 2 If Yes, Give Year or Date	⊠ No		Yes 2 No				Specify		/hite
r, tre Marical Ex.		Decedent's l	Education rede completed)		(Give kit	nt's Usuel Occu	during mos	st of workin	9	16b. Kind of Bu	siness/Indu	ustry
	Elementary/Secondary	y (0-12)	College (1-4	or 5+)		NOT use retire inistra	,			Federal	Correr	nmont.
	12 17. Fathar's Nema (First	t, Middla, Las	st)		21(1)11	IIIISCIA	_	er's Name		Maiden Sumem		innenc
To Be	Albert Hu	ghes						Clar	a Marsh	nall		
all a	19a. Informant's Name/F				19b. Melling	Addrass (Stree	et end Numb	er or Rurel	Route Numbe	r, City or Town,	Stete, Zip (	Coda)
1	Eileen F.		es (w	lfe)		Boyer P	lace,	Silv	-		2091	
or of	20e. Method of Disposition 1 Disposition 2 Cree		Ramovel from Sta	te Ce		tory or other pla		İ	Dete	20c. Locetion -		
Important: If item 27 is any injury or other tre	4 Donetion 5 D			Gai						Silver		
any i	21. Signature of Funerel Servica Licensee  22. Name and Address of Fecility Francis J. Collin Home, Inc. 500 University Blvd. We Silver Spring, MD 20901										ns Fu lest	ineral
	23a. Pert1. Enter the dis	n D	Tynd	sed the deeth	Sil	ver Spr	ing, l	MD 2	0901			Approximate
ician	shock, or heart fell	lure. List on	y one ceuse on eec	line.	. Do not office	ino mode or dy	11.9, 00011 00	our diago or	respiretory an	10011		Intervel Between Onset end Deeth
edical	Immediate Ceuse (Finel disease or condition	d.	CAR	AIGI	-CAY	2RFS	T				1	
niner	resulting in deeth)		0.	Due to (or	es e conseque	ence of):	101		- 1			
line			W),	10C/	KRDIA	LIA	1+A6	CCT	ON		i	
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9 6	cause. Enter Underlying Causa (Disaasa or injury that initiated avants	y $<$	c	0140	NACT	HKI	ER	(U)	1200	35		
	resulting in death) Lest			Due to (or	es é conseque	nce or).					1	
r usa			d								1	
deteched for usa as // Physician/Mec	Pert II. Other significant	t conditions	contributing to deat	but not resu	ilting in the und	erlying cause g	iven in Pert	l.	23b. Dld t	obacco uee cor	ntribute to	the cause of death?
Phy	RULMON	VARY	EMB	OLL.	PUI	MON	JARY		101	res 2□ No	3 Prob	ably 4 Unknown
d be	CIRCAL	_					. ,		24e. Wes	an aufonsy	24b. Wei	e eutopsy findings
C 3 4	110005	5								med?	COLL	lable prior to apletion of cause eeth?
shou									1 🗆 Y	es 20 No		Yes 2□ No
ige 2 shou							26 Plac	o of Dogth	(Check only o	, /		Tes ZLINO
or, page 2 should be deteched for usa as e Completed by Physician/Me	25. Wes case referred to	o medical		ations ASS	ER/Outpetient	3 DOA O	ther			lence 6 Oth	er (Specify	
Be Be	25. Wes case referred to examiner?  1 Yes 2 No	o medical	Hospital: 1 Inp	1 Inpatient PREHOUTPETENT 3LI DOA 4LI Nursing F								
director O Be	examiner? 1 Yes 2 No 27. Menner of Death		28a. Date of I	niury	28b. Time of Injury	28c. Inju	ork?	28d. Dascribe how injury occurred No				
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al director	examiner?  1 Yes 2 No  27. Menner of Death  1. Naturel 5 [ 2 Accidenf 3 Suicide 6 [ 4 Homicida  29a. Certifiar (Check only 2	☐ Panding investigation of the could not datermine  *Certifying P  *Medical Example of the could be c	28a. Date of (Month, on be d 28e. Place of building, hysician: To tha be	Injury - At ho atc. (Specify st of my knows of axaminat	Injury me, farm, stree )	M 1[ t, fectory, office ccurred et the t stigation, in my	Yes 2	No 2	City or Tow	m, Steta) cause(s) end me	nner es sta end due to	ated. the ceuse(s)
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 18, AUGUST JAMES LLOYD HOLBERT 1998 3:30 am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Nama (If not institution, giva straet and number) Examiner SLIGO CREEK NURSING & REHAB. CENTER TAKOMA PARK MONTGOMERY If Undar 1 Yaar 8. Date of Birth (Month, Dey, Ye 9/24/01 Birthplece (State or Foraign Country)
 WV 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 1ÅM 2□ F Months Deys Hours 96 Yrs Director 578-01-1383 Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Heelth and Mentel Hygiene. Important: if itam 27 is marked other than "natural", or florms 23s or 23s-f show any injury or other traumatic event, the Medical Examiner must be not fled once. 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits MD MONTGOMERY TAKOMA PARK 1 ☐ Yas 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7608 GLENSIDE DRIVE 20912 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14 Race - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Spacify: Specify: p 3 ₩ Widowed 4 Divorced WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INSURANCE SALES INSURANCE 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last)
JAMES EARL HOLBERT Be AMANDA I. MYRTIE EVERLY 10 19b. Mailing Address (Street and Number of Rural Boute Number City or Town, Stete, Zip Code) BROWN SCREEK ROAD, ROUTE 18-5 19a. Informent's Name/Relationship (Type, Print) DEAN ROUX/NIECE MINEVEH, PA 15353 20b. Placa of Disposition (Neme of cematery, crametory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Suriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON CEMETERY 8/23/98 21. Signature of Funerel Service Licens 22 TAKOMA FUNERAL HOME 254 CARROLL STREET, N.W., WASHINGTON, D.C. Wex 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximata Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Finel disaese or condition resulting in deeth) ASPIRATION PNEUMONIA DAYS Examiner Due to (or es e consequence of).
NEUROGENIC DYSPHASIA Examiner WEEKS physician and the buriel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last Due to (or es e consequence of): CEREBROVASCULAR ACCIDENT P.O. Box 68760 WEEKS Physician/Medicai Dua to (or es a consequenca of) 80 HYPERTENSION YEARS 987 signed by the a 23b. Did tobacco use contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? Completed peen completion of cause of deeth? page 2 s has certificata 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Wes case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 2 Accident Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation efter deatl Director: 6 Could not be determined 3 Sulcide Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 • Funeral Dire 4 Homicide Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted.

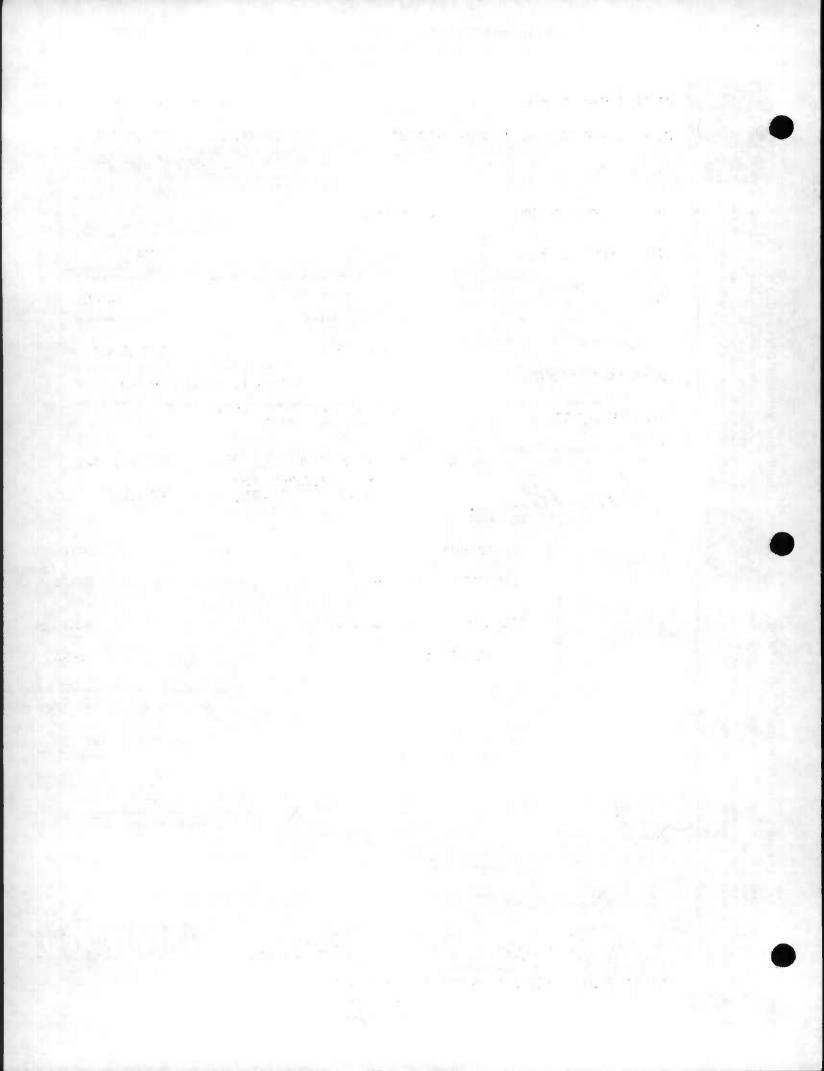
Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier edical completaly (Check only one) To the To the To the 29b. Signature and the of certifier 29g. License number 29d. Data signed (Month, Day, Year) 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) NORTON ELSON 6525 BELCREST ROAD, HYATTSVILLE, MD 20782

DHMH 16 Rav 6/95

Registrar

31. Dete filed (Month, Day, Yeer)

32. Registrer's Signeture



	Pleas	se Type or State o			/ Dep	artme	nt of	Health a		II Copies Ilental Hy			26728
					Ce	ertifica	ite of	Death			Reg. No.		
1. Decedent's Name (Fir			-							2. Dete of De Month	eth Dey	Yeer_	3. Time of Deeth
THOMAS		HENNI	GAL	)						78	15	1998	8:26 AM
4a. Fecility Neme (If not	institution,	give street end nu	umber)					4b. City, Tow	n, or L	ocation of Deat	h 4c. Cour	nty of Deeth	
POTOMAC VAL	LEY N	URSING H	OME					ROCKVI	LLE		MONTO	GOMERY	
5. Sociel Security Number	er (	6. Sex	7. Age (	In yrs. les	st birthdey,		er 1 Year			8. Date of Bir	th	9. Birthp	lace (State or Foreign
047-16-7545		1/□fM 2□ F	73		Yrs.	Months	s Deys	Hours	Min.	(Month, De FEB • 2	8-1925	Cour	ECTICUT
Usual Residence of Deci	edent											001111	
10a. State 10b	. County		1	Oc. City,	Town or L	ocation						1	0d. Inside City Limits
MD P	RINCE	GEORGES		HYAT'	TSVIL	LE							1 ☐ Yes 2 ☐ No
Oe. Street and Number						10f. 7	ip Code				10g. Citizen o	f What Cour	11 11
	A 3772					101.2		700				Wilet Cour	my r
000 FAIROAK	AVE.	40 5			T			783			USA		
Marital Status     Never Married     Widowed 4		12. Was Dec Armed F d 1/D/Yes If Yes, Gi Yeer or D	orces? 2 No ive	1943 1946	/ 13.	Was Decilf Yes, sp	edent of ecify Cul	Hispanic Origi pen, Mexican, Specify:	n? (Sp Puerto	ecify Yes or No Rican, etc.)	В	aca - Americ leck, White, cify: WHI	etc.
15. [	Decedent's	Education			16e. Dece	dent's Us	uel Occu	petion			16b. Kind of	Business/Inc	fustry
(Specify on	nly highest	grade completed)	-		(Give	kind of w	ork done	during most of	of work	ing		22.000	-,
Elementery/Secondary	y (U-12)	College (	1-4or 5+)		CHEMI						AEROSI	PACE	
7. Fether's Neme (First,	Middle. La				OLLULI	. UIIU .	1101		s Name	e (First, Middle,			
HOMAS HENN										MEEHAN	Worden Came	sino,	
19e. tnforment's Neme/F GLORIA WORCI 20e. Method of Disposition 1 □ Buriel 2/□#Cre	H HEN	NIGAN (		20b. Pled		FAIR	OAK eme of	AVE. H		POINTE Number SVILLE  Date		0783	
4 Donetion 5 0			1	FT.	LINCO			TORY ess of Fecility		-17-98   NES-RIN	BRENTV		MD EW HAMPSHI
200	2	Myl	9		A	VE.	SILV	ER SPR		, MD 20		1000 N	LW HAITI SILL
23a. Part1. Enter the dis shock, or heart failu Immediate Ceuse (Final disease or condition resulting in deeth)	ure. List or	e. CAPI	OPU	HOI	Do not en	71	ARF	ing, such es co	ardiac (	or respiretory e	rrest,	11	Approximete intervel Between Onset end Death
Gequentielly list conditlor f eny, leeding to Immedi seuse. Enter Underlying Ceuse (Diseese or injury	ate I	■ b. CA	2410	OHF		= 4	NG	, ME	TAS	STATIC	7		ZTEARS
thet Initiated events resulting in deeth) Last	1	d	Due	e to (or e	s e consec	quence of)	:						
Pert II. Other significent	conditions	contributing to de	eath but n	ot resulti	ng In the u	inderlying	cause gi	ven in Pert I.			tobecco use d Yes 2□ No		the cause of death?
										24a. Wes	en eutopsy rmed?	eve	re eutopsy findings illeble prior to npletion of ceuse deeth?
										101	res 2500	1 🗆	Yes 2 No
5. Was cese referred to	medical							26. Plece o	f Deeth	h (Check only o	ne)		
examiner?		Hospital:	Inpatient	2□ EF	VOutpatier	nt 3 D	OA Ot	nort a d		me 5□Resid		ther /Specifi	•)
7. Manner of Deeth	] Pending	28a, Dete		28	3b. Time of		28c. Inju Wo			28d. Describe			,

by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed

Physician

/Medical Examiner

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

**Physician** 

/Medical

**Examiner** 

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "neturel", or items 23e or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

P

3 Suicide

29a. Certifier (Check only one)

29b. Signature a

4 Homlcide

State Registrar

31. Dete filed (Month, Dey, Year)
AUG 19 1998

6 Could not be determined

129 LAURENTON
32. Negistrer's Signeture 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

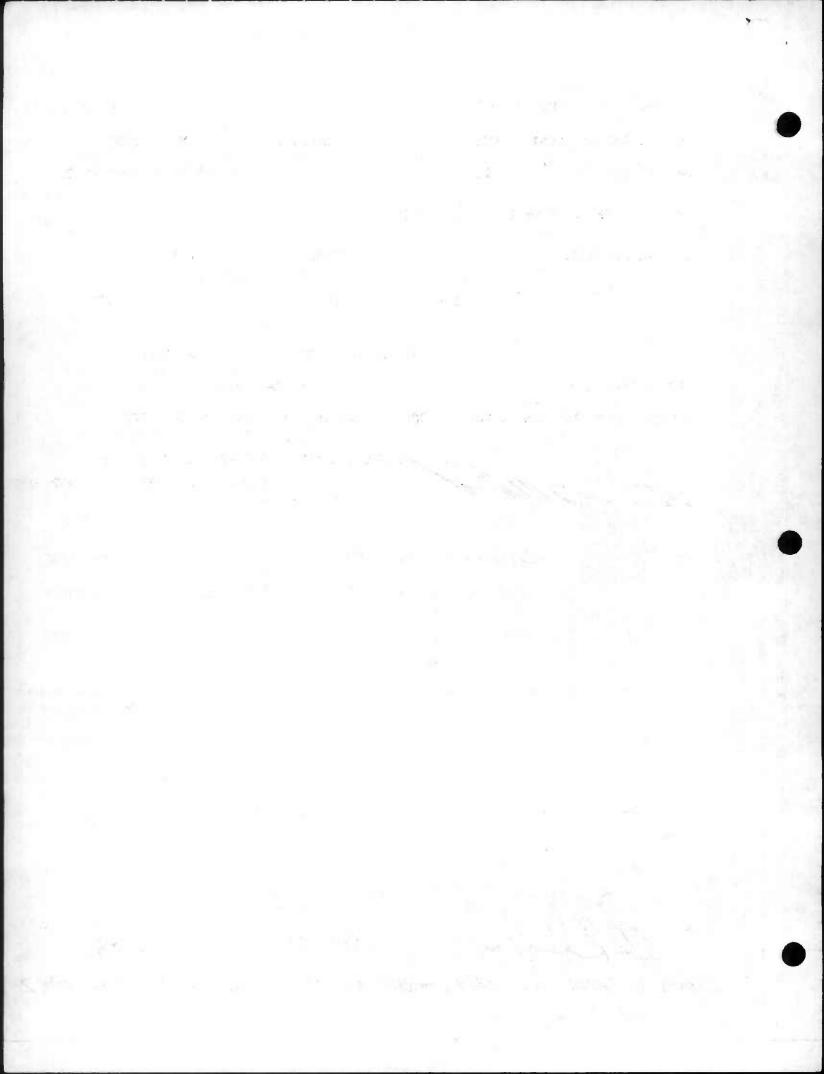
1 Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medicel Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

SILVER SPRINX-OID 20902



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUG. **Physician** 17, 1998 MAILLIAM E. HALL 2:35 AM /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2906 BLUERIDGE AVE. WHEATON MONTGOMERY 5. Social Security Number 6. Sex If Under 1 Yeer If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours Yrs. 86 **Director** 215-05-0098 WASHINGTON .D. C 16, 1911 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "naturel", or itams 23s or 28s-f show the Medical Examiner must be notified at Director 1 X Yes 2 □ No MD. MONTGOMERY WHEATON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with BLUERIDGE AVE. 2906 20902 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Biack, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 9 SUPERVISOR DRY CLEANING CO. marked other permit. Pages 1 and 2 should be file Department of Health and Mentai Hy Important: if item 27 is merked othe any Injury or other traument 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE T. HALL LUCILLE HAYDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) JOHN P. HALL / SON AS TTEM 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/18/98 CHAMBERS CREMATORY RIVERDALE, MD. 21 Signature of Funeral Service Licenses 22. Name and Address of Facility 20910 LLARS M00091 CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final GASTRIC CAWCER MOS disease or condition resulting in death) Examiner Due to (or as a consequence of) bunel-trensit Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest end Due to (or as a consequence of): Box 68760. physician certificate be Physician/Medical the 1 Due to (or es e consequence of) 98 ettending esn 0 P.O. Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contribute to the cause of death? detached signed by to 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes an autopsy performed? peen : Completed pege 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Deeth 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury et Work? or Attending F efter death. Director: After After 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide 24 hours Hospital 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) STEPHEN STAM WERCANTICE CONE LARGO US 20799 1221 - MO

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 8 1998

32. Registrar's Signature

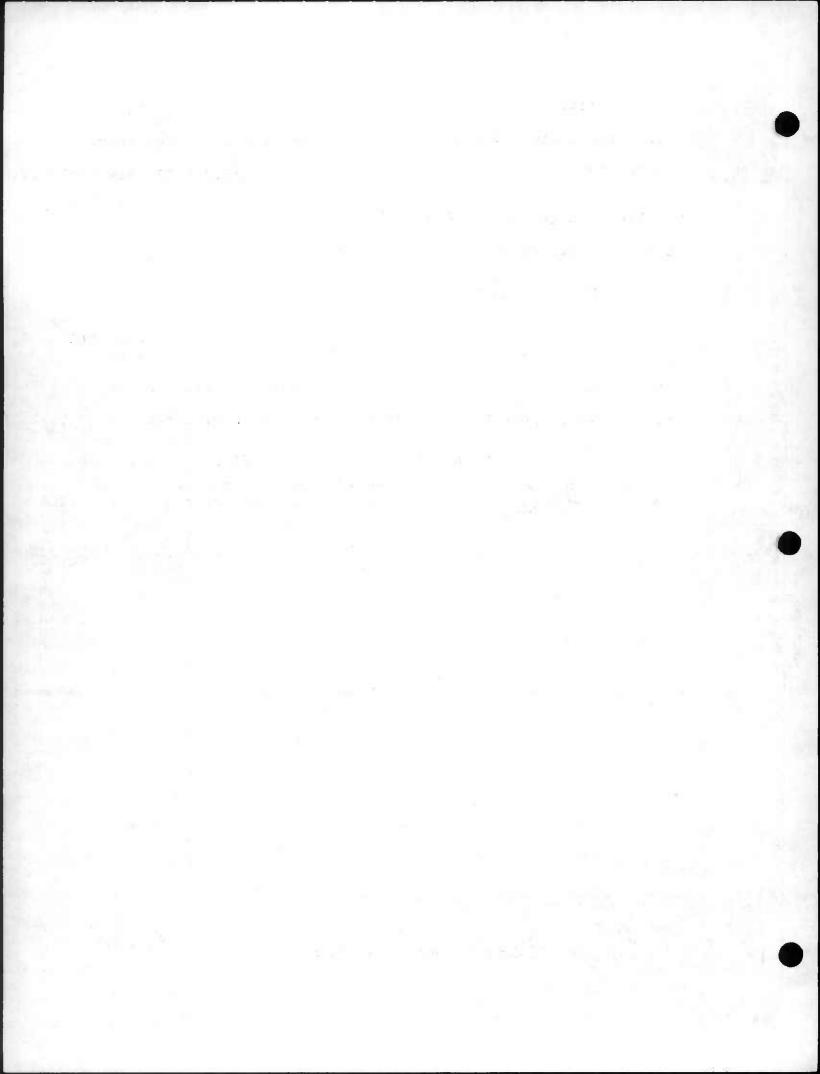
DHMH 16 Rev 6/95

Maria Jan Landon Albanda Alban 3 THE ROLL PROPERTY AND ADDRESS. LI. LY, LIST TALLEYTEIN, 25 to 10 5 10 10 1 . IT BEEN TO SEE . E. LEIGHE I IV the Market of the Market of the Asset of the first in making with the mineral control of the long friendly life in a

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Daath 3. Time of Daeth **Physician** Louis Hecht 9:15am 17, 1998 /Medical August 4e. Facility Name (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 8100 Connecticut Avenue Chevy Chase Montgomery 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs. Months Days Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthpleca (State or Foreign Country) New York, N. Y **Funeral** Days 11 M 2□ F 050-10-3191 85 Yrs Director Jan.3,1913 New Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at Director Chevy Chase Maryland Montgomery 1X Yas 2 □ No 10e. Street end Number 10f. Zip Code 10g. Cltizen of Whet Country? 20815 8100 Connecticut Avenue U.S.A. Peges 1 end 2 should be filed within 72 hours efter death nent of Health end Mental Hygiene. Funeral 14. Raca - Amarican Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) I ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Marriad 2 Marriad 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Architectural end Mental Hygiene. Elementary/Secondary (0-12) Architect Firms Baltimore, Maryland 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surnema) Be Harry Hecht Ida Horowitz 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3391 Stephenson Pl.N.W.Washington, 20015 permit. Peges 1 end 2 Department of Health e Important: If Item 27 Is any Injury or other tra Marjorie Watson/Daughter 20b. Pieca of Disposition (Neme of cematary, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 DBuriai 2 Cremation 3 Removel from Stete 4 Donation 5 DOther (Specify) Mt. Lebanon 8/18/98 Adelphi, MD 22 Nama and Address of Facility
Ives-Pearson Funeral Home 21. Signature of Funeral Sarvice Licensae Bru. 2847 Wilson Blvd. Arlington, VA 22201 P n1. Enter the disaase, or compile shons thet causad tha daath. Do not enter the mode of dying, such es cardlec or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Myochnois/ Infinction /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner or Attending Physician: The law requires that the death certificate be executed buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last pue Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, ettending physician for use es the burie Physician/Medical Due to (or as a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by the should be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by Completed 24b. Were eutopsy findings evailabla prior to completion of cause of death? 24e. Wes an autopsy performed? page 2 certificete 1□Yas 2⊠No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Director: After this d in by the funeral di 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Deeth Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcida Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, and due to the ceuse(s) end mennar steted. 29a. Certifier 29b. Signetura certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5530 Wisconsin Ave. Chevy Chase, MD Gary Fisher, 31. Date filed (Month, Day, Year) MD 32. Registrar's Signeture State AUG 1 9 1998 Registrar



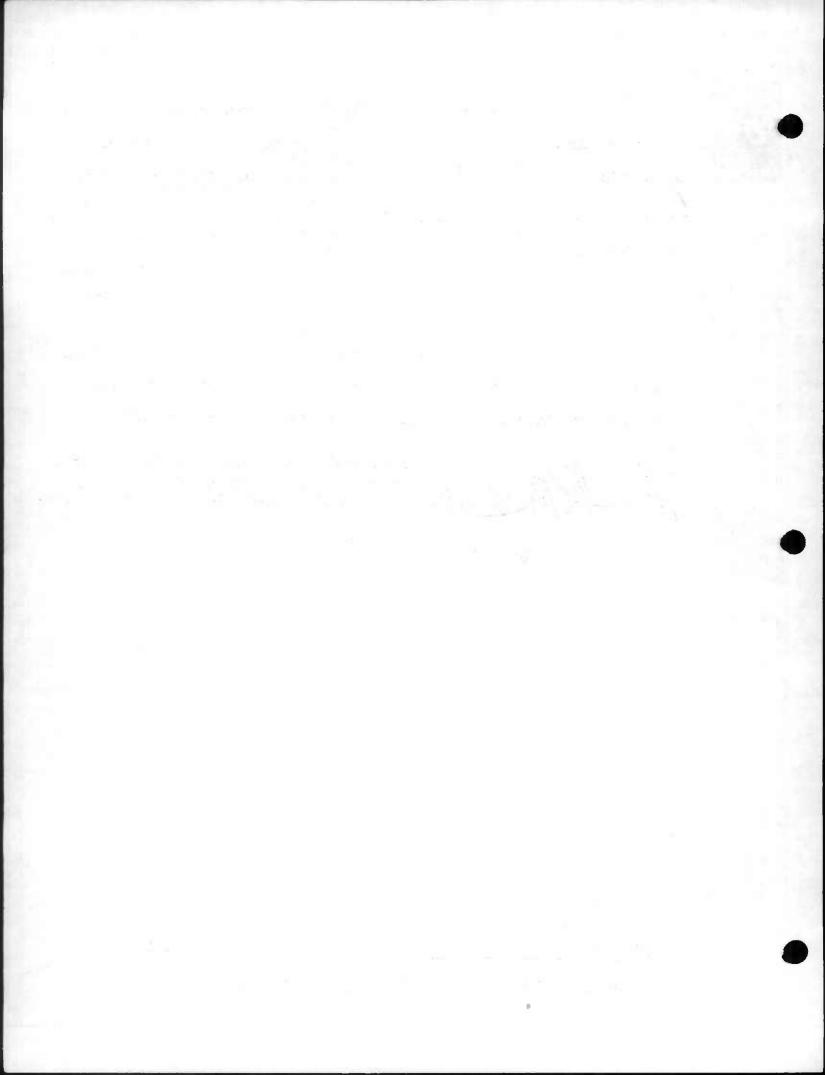
State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Marie Hayes 18, Aug. 1998 9:32 A.M. /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2304 Pine Street Harford Edgewood If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Day, Yeer) 6. Sex 7. Age (In yrs. last birthdey) **Funeral**  Birthplece (State or Foreign Country) 1 M 2 StF 91 Yrs. Director 220-20-7639 June 16, 1907 Maryland death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show iner must be notified at Director 1 ☐ Yes 20 No Maryland Harford Edgewood 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2304 Pine Street 21040 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Maritel Status The Medical Examiner filed within 72 hours after 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yes 2 ➡ No Specify: by Specify: White 3 ☑ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Lab Technician 8 U.S. Government traumatic evant, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be if Item 27 is marked o Peges 1 end 2 should be **Jeffers** (MMN) Lena (MMN) Gutermuth 2 James 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8525 Oakleigh Road, Baltimore, MD 21234 David E. Jeffers/Nephew other 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any Injury or once. 4 Donetien 5 Other (S Air Memorial Gardens 8-20-98 Bel Air, Maryland 22. Name end Address of Fecility
Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a Part1. Enter the dis eath. Do not enter the mode of dylng, such es cerdiac or respiretory errest, Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final S C V D A disease or condition resulting in death) Examiner Due to (or es e consequence of) The lew requires that the death certificate be executed burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue Due to (or es e consequence of): inding physician use es the burial P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): ed by the ettending p detached for use es Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Dld tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, by page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause Completed 24a. Was en eutopsy peen of deeth? hes 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 10 1 Nes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ò within 24 hours of To the Funeral I 1 Certifing Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. 29a. Certifier Medical (Check only nature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Yeer) OCME Aug. 18, 1998 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Ganesh Prabhu, 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State Registrar AUG 2 0 1998

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State of Maryland / Department of Health and Mental Hydiene

partificit of i	leall and	Melital	riygiche	0	0
ertificate of	Death		Reg. No.	3	0

	Funeral Director
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Mayland Depertment of Health and Mentel Hygiane. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.

**Physician** /Medical Examiner physician and s the burial-transit that the death certificate be executed Division of Vital Records, P.O. Box 68760, 98 USB ŏ signed by the e cartificata has t diractor, paga 2 s I or Attending Physician: eftar death. Director: After this cartifica diractor, funeral To the Hospital or within 24 hours effit To the Funeral Dir completely filled in

1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Yee **Physician** James Leon Haines AUGUST 15, 1998 0845 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore 140 at WOODFIELD COURT REISTERSTOWN If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year, Birthplace (State or Foreign Country) Months Deys 1⊠M 2□ F 80 162-12-2371 Feb. 20, 1918 PA Usuel Residence of Deceden 10a Stete 10b. County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☐ No Director Baltimore Lutherville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 Trelawny Court 21093 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Merital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Lutheran Minister Clergy 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be J.Lester Haines Anna Hubler 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) -Wife 5 Trelawny Court Lutherville, MD 21093 Angeline Haines 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Burlal 2 □ Cremetion 3 □ Removel from State 8/19/98 Littlestown, PA Mt.Carmel Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Littles'F.H.34 Maple Ave.Littlestown, PA17340 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initioted events resulting In death) Lest Due to (or es e consequence of): Physiclan/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? 2 - No Yes 2 No 25. Wes cese referred to medicel exeminer? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) At Scene 2 XXX es 2 No 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of Certification: Injury 1 Naturel 5 Pending 16.5 128 in out o acciden investigation 0820A 2 Sulcident 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number Octiv or Town, State) 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 140 and Woodfield Co REET 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

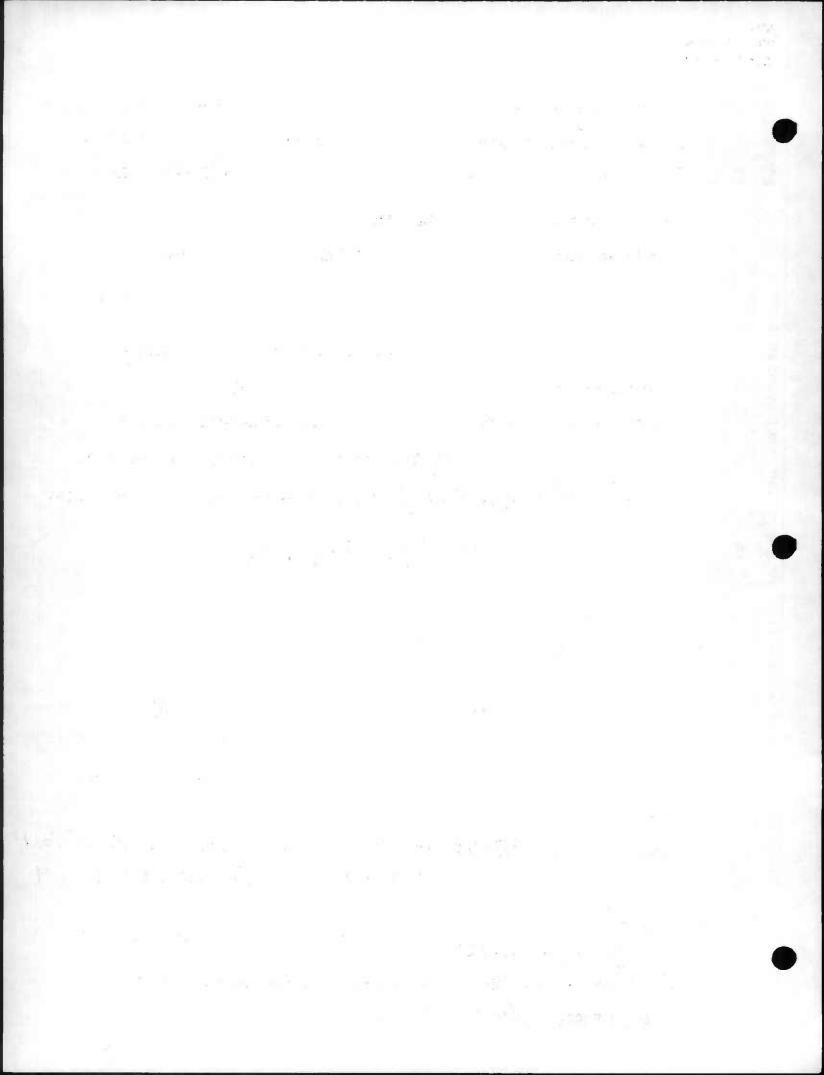
\*\*Medical Examiner: On the bests of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29a, Certifies Medical 29d. Date signed (Month, Dey, Year) 29b. Signah and title of certifier 29c. License number AUGUST 16, 1998 OCME no completed cause of death (Item 23a) (Type, Print) ress of person LOCKEIND AKON 111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)

AUG 1 8 1998

32. Registrer's Signeture



BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

E HOSPITAL OR ATTENDING PHYSIS E FUNERAL DIRECTOR; After this of within 72 hours after death with TO THE HOSPITAL

TO THE FUNERAL I

Be filed within 72 h

IMPORTANT: If II

Item 28

30. NAME AND HAFF

31. OATE FILEO (Month, Day, Year)

AUG 1 8 1998

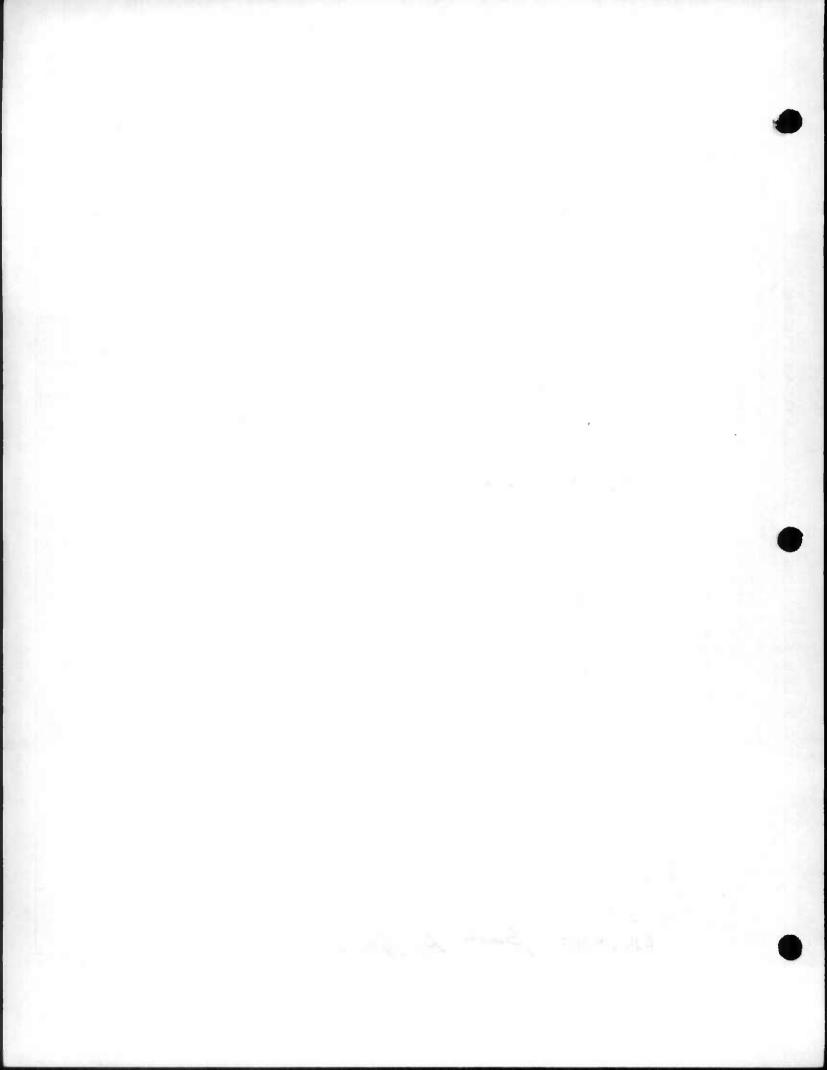
32. REGISTRAR'S SIGNATURE

VDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	1. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	r death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
e law require	has been sig	Dept. of Hea	23 shows
ICIAN: The	ertificate	the State	or Item
NDING PHYS	: After this c	r death with	is marked,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH VEAD IDIIPM Clyde L. B. Harner 1998 August 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) May 5 IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 1 XM 2 F 76 YRS. 168 - 14 - 1550Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 4325 Hampshire Rd. DIRECTOR Carroll Hampstead RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Carrol1 Hampstead 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4325 Hampshire Rd. 21074 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 (∑ YES 2 □ NO IF YES, GIVE WAR OR DATES, 1 -43 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, atc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced white 18e, DECEDENT'S USUAL OCCUPATION
(Given kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 186. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 12 Tool & Die maker Small Tool Manufacturer 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Mervin J. Harner Laura Reinaman BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bonnie Harner 4325 Hampshire Rd., Hampstead, MD 21074 20b. PLACE OF DISPOSITION (Name of cometery, cremetory) / 18/98 20c. LOCATION — City or Town, State St. John's Lutheran Cemetery 4 Donation 5 Other (Specify) Littlestown, 21. SIGNATURE OF FUNERAL BERVICE LICES 22. NAME AND ADDRESS OF FACILITY Littlestown, PA 17340 444 Little's Funeral HOme 34 Maple Ave. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heert fellure. List only one ceuse on each line. Interval Between Onset end Death IMMEDIATE CAUSE (Finel diseese or condition 34R3 resulting in death) DUE TO (OR AS A CONSEQUENCE OF PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditione contributing to deeth but not resulting in the underlying ceuee given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? CARCINOMA COLDN 1 YES 2 - 40 OF DEATH? 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 YES 2 NO HOSPITAL: OTHER: ne 5 Reeldence 8 - Other (Specify) 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27. MANNER OF DEATH 28c. INJURY AT WORK?
1 YES 2 NO 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending trivestigs BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homtelde 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner se stated. 29d. DATE SIGNEO (Month, Day, Year)

8 18 98 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE DDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 15, FRANCES ELIZABETH McINTOSH HUBBELL AUGUST 1998 11:00 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 27318 REST CIRCLE **EASTON** TALBOT If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number if-Under 1 Yeer 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) 1□ M 21 F Yrs. 057-24-8465 74 AUGUST 12, 1924 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Yes 2 No WESTCHESTER PELHAM 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 206 CLIFF AVE. 10803 USA 11. Maritet Status 12. Wes Decadent Ever in U,S Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American tndien, Bleck, White, etc. 1 ☐ Yes 2 X No tf Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ▼ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 HOME MAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES R. McINTOSH FRANCES MILLER 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 CLIFF AVE., PELHAM, NY., DAVID B. HUBBELL 10803 20b. Ptaca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriat 2 X Cremation 3 ☐ Removel from State CHESAPEAKE CREMATION CTR. 8-16-98 CHESTER, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P. A. M. Ostrowsk. Joseph 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory airest, MD. 21601 shock, or heart feiture. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth tmmediate Ceuse (Finel disease or condition resulting to death) o. Arteriosclerotic Cardiovascular Disease years Due to (or es e consequenca of): Sequentietly tist conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting In death) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Chronic Pulmonary Emphysema 24b. Were eutopsy findings 24e. Wes en eutopsy

Physiclan /Medical **Examiner** 

The law requires that the death certificeta be executed

P.O. Box 68760

Records.

Division of Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or itams 23a or 28a-f shov adical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 Ie marked other than "natural", or item any injury or other traumatic event, the Medical Evaruran

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

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the Maryland

death

Examiner Physician/Medical Be 2

pue the ettending for use es the à been signed t should be det þ Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t edicai Certification:

						pe	erformed	17	completion of cause of deeth?
						1	☐ Yes	2 No	1 ☐ Yes 2 ☐ No
25. Wes case referred to med	icat				26. Place of De	ath (Check on	nly one)		
examiner? 1 X Yes 2 □ No	н	ospitel: 1 - tnpetient 2 -	ER/Outpetient 3□	esidenca	a 6 Other	(Specify)			
Z L ACCIDENT	stigation	28a. Dete of tnjury (Month, Day Year)	28b. Time of Injury M	28c.	tnjury et Work? 1   Yes 2   No	28d. Descri	be how I	njury occurre	d
	old not be ermined	28e. Placa of tnjury - At h- building, etc. (Specif	ome, ferm, street, fac	tory, of	281. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 ☐ Certifier (Check only one) 1 ☐ Certifier Medic	ying Phye al Examtn	tclan: To the best of my kno er: On the basis of exemine	wledge, deeth occurr tion end/or investigat	ed et ti	he time, date end ptac my opinion, deeth occ	e, end due to t urred et the tin	the ceus	e(s) end men end place, en	ner es steted. nd due to the cause(s)

State Registrar

219 S. Washington St., Easton, MD 21601 David Allan Stout, M.D.

31. Dete filed (Month, Day, Year) AUG 1

30. Name end eddress of person who completed ceuse of deeth (ttem 23e) (Type, Print)

29b. Signeture end title of certified

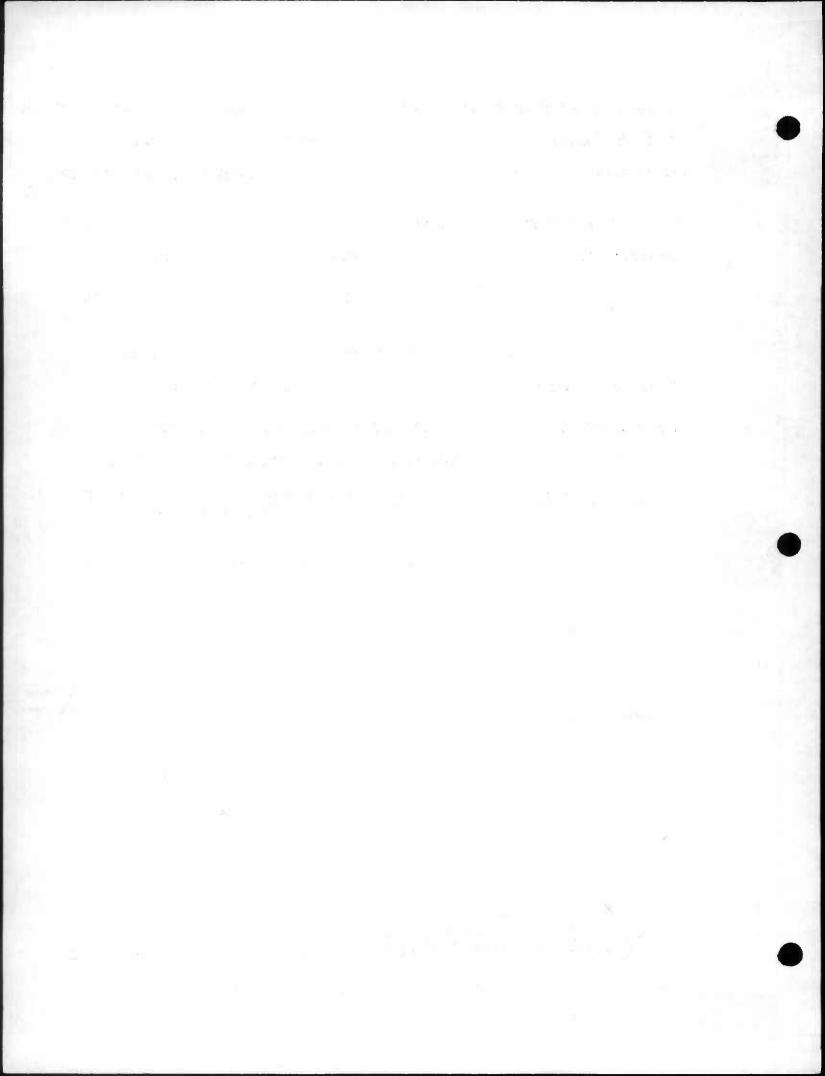


29c. License number

D06804

29d. Date signed (Month, Day, Year)

August 15, 1998



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		4 December 19 November 19 19 19 19 19 19 19 19 19 19 19 19 19		Certifica	te of Death		g. No.	
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/Medi Exami		4a, Facility Nama (If not institution,	iva streat and number)	Jones	4b. City, Town, o	Location of Deeth	4c. County of	
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or 28s	Funeral Director	10e. Street end Numbar	- 01 1	0 101.2	ip Code	10	g. Citizan of Wha	at Country?
eath with rs 23a or rsust be	erail	128 LEIS1E	es Chueck	KD C	2113+		USA	4
or ite	by Fund	11. Marital Status  1 □ Navar Marriad 2 □ Married  3 □ Widowad 4 □ Divorcad	12. Was Decedent Ever Armed Forces? 1   Yes 2   No If Yes, Give Year or Dates:		edant of Hispenic Ortgin? (ecify Cuban, Maxican, Pua 2 No Spacify:	Specify Yas or No- rto Rican, atc.)		American Indian, Whita, atc.
	eted	15. Dacadant's (Specify only highast of	Education	16a. Dacadant's Us	ual Occupation	1 1	6b. Kind of Busin	ass/Industry
d within giana. or than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life, DO NOT	rork dona during most of we use ratired)	Jining	HOM	6.
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d 2 should be filed within th and Mental Hygiana. 7 is marked other than traumatic event, the M	ToE	EUGENE DU	LIPREE BIS	hop	BET	HE HAR	EWELL	
iges 1 and 2 should be filed within 72 ho to Haalth and Mental Hygiena. If itam 27 is marked other than "natur or other traumatic event, the Medical		19a. Informant's Name/Relationship	Type, Printy	19b Mailing Addre	ss (Street and Numberlor F	Rural Routa Numbar,	WESTM	NSHEE, MA
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permit. Departr Importa any inje		SYCA		PRIH	5 FUNEEAL	HONE !	MAPEL	En 41 2115
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Examiner		disaase or condition resulting in daath)	aA	ute un o cond	and inforcti	~		abusin!
70 %	iner		Doa	o (or as a consèquence of	).			1
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ificate be ay physician as the bunal	edicai E	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated evants	C. Due t	o (or as e consequence of				
- D 60	92	rasulting in daath) Last	I d					
death ne atte ed for	Physician/N	Part II. Other significant conditions	contributing to death but not	rasulting in the undarlying	causa givan in Part I.	23b. Did tob	acco uae contri	oute to the cause of death
uires that the death cert signed by the attendin d be datached for use								Probably 4 triknow
aw requals been 2 should	Completed by		9.85			24a. Wes an perform		4b. Wera eutopsy findings available prior to completion of cause of death?
e de ge						1 □ Yas	2 2 No	1 Yas 2 10
		25. Wes case rafarred to medical axaminar?	Hospitai:		04	ath (Chack only one		
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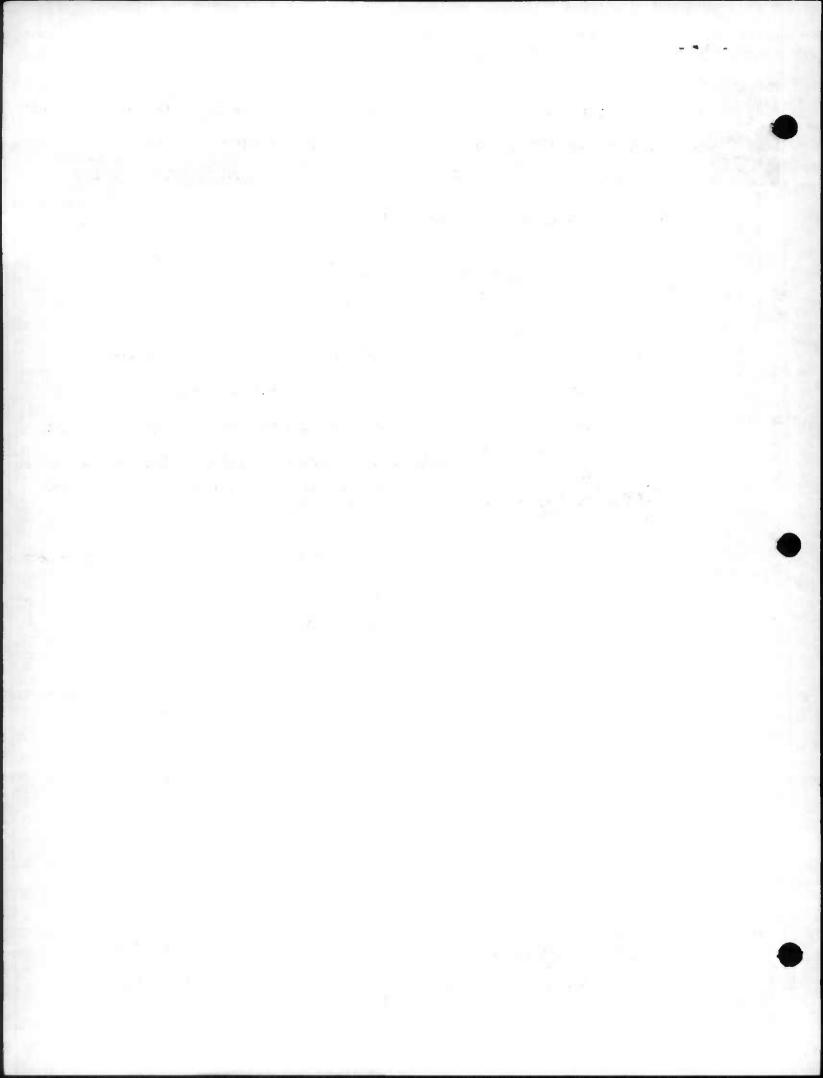
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State of Maryland / Department of Health and Mental Hygiene 98 26736

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Funeral		5. Social Security Number	6. Se		Age (In yrs. le			1 Year	If Under	24 Hrs.		1	9. Birthple	ace (State or Foreig
Director		213-22-8448 Usuel Residence of Decedent	1[	⊒м <b>җ</b> ⊒ ғ	70	Yrs.	Months	Deys	Hours	Min.	8. Dete of Birth (Month, Day Sept.19	,1927	Mary.	Land
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7 28 x 28	<b>Funeral Director</b>	10e. Street end Number					10f. Zip	Code			1	0g. Citizen of	What Count	ry?
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deat deat	ner	11. Maritel Status		12. Wes Deceder	nt Ever in U,S	. 13.	Was Dece	dent of H	lispenic Or	gin? (Sp	pecify Yes or No- Rican, etc.)	14. Ra	ce - America	
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efter death. Director: After	Certification:	3 ☐ Suicide 6 ☐ Could		28e. Place of I	tnjury - At hom	ne, farm, str	eet, fectory	, office			28f. Location (S	reet end Num	ber or Rurel	Route Number,
Dire	eri	4 Homicide determination	illiou	building,	etc. (Specify)		, , , , , , ,	,			City or Town	n, State)		
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## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month Year

**Physician** /Medical Examiner **Funeral** Director with the Maryland r 28a-f show Directo r than "natural", or items 23a or the Medical Examiner must be Funerai by

filed within 72 hours after deeth Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be file Department of Health end Manial Hy Important: if Item 27 is merked oth any Injury or other traumatic event

> **Physician** /Medical Examiner

physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pl for use as t signed by the is certificata has I Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice in by

1. Decedent's Neme (First, Middle, Last) Dale Koenig 1998 1:30 P.M. August 12 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Montgomery Suburban Hospital Bethesda 5. Sociel Security Number 7. Age (In vrs. lest birthdev) If Under 1 Year If Under 24 Hrs. Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) Months Days Hours 12 M 20 F Jan. 21, 577-03-2662 82 Virginia 1916 Usual Residence of Decedent 10c City Town or Location 10d Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5714 Aberdeen Road 20814 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merriad 2 ☑ Married Specify: White If Yes, Give Yaar or Dates: WW II 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electric Company 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Be Adolph Koenig Mary Ashbey 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Louise D. Koenig/Wife 5714 Aberdeen Road, Bethesda, Maryland 20814 20b. Placa of Disposition (Neme of cematary, crametory or other place Aug. 17, 1998 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Chase, Inc. Bethesda, Maryland 20814-3501 a of Funeral Service Licensee M00198 23a. Part1. Enter rie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failura. List only ona causa on each line. Approximate Interval Between Onset end Death Firshot Wound of Heng Immediate Causa (Final disease or condition rasulting in death) Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Due to (or es e consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Wara autopsy findings eveilable prior to complation of causa of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? Be 26. Placa of Daath (Check only ona) examiner? 1. Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Natural Blot 8(11/93 0625 HX 2 Accident

To the Hospital or within 24 hours eft To the Funeral DI Completely filled in edicai 54

> State Registrar

30. Nama and addrass of person who completed cause of peath (Itam 23a) (Type, Print) THEODORE Miking 31. Date filed (Month, Day, Yaar) AUG 1 8 1998

6 Could not be detarmined

Suicide
Homicide

(Check only one)

29b. Signeture end title of certifier

29a. Certifier

22. Registrar's Signature apera

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

111 Penn Street, Baltimore, Maryland 21201

| Gracing of Jown, Stete) 5714 Aberduce
| Gracing of Jown, Stete) 5714 Aberduce
| Gracing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marker as stated.
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

on (Street end Number or Rural Route Number, Town, Stete)

29d. Date signed (Month, Dev. Year)

August 13, 1998

Aberdu Los

ete) 5714

or

SECTION AND ADDRESS OF THE PROPERTY OF THE PRO Selfficial Self-

State Registrar 31. Dete filed (Month, Day, Year)

JOSEPH D.

AUG 1 9 1998

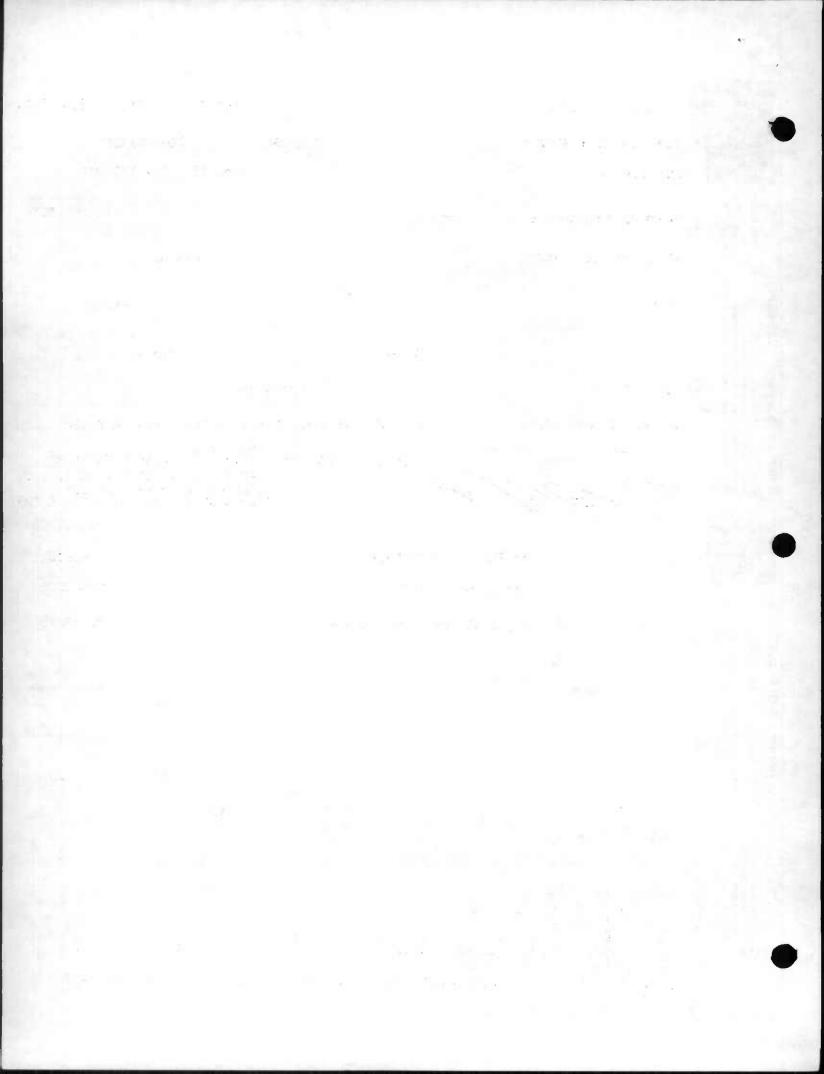
CONNOR, MD.,

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sparks

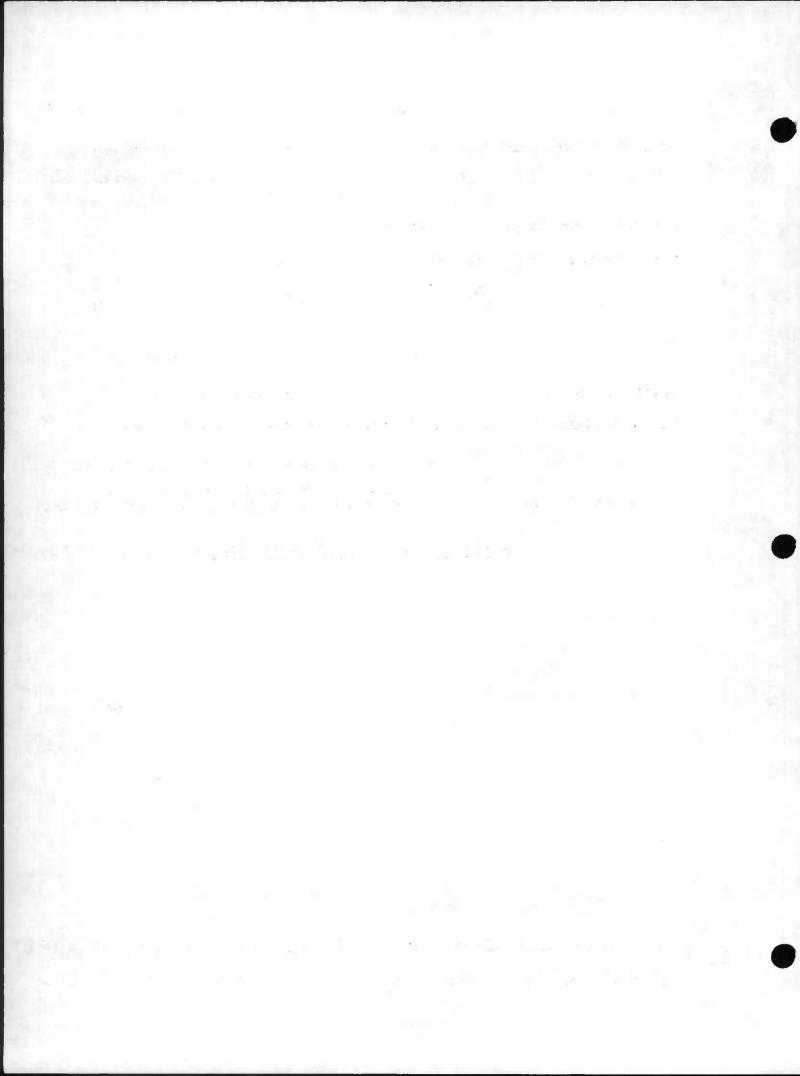
6000 EXECUTIVE BLVD. #300, ROCKVILLE MARYLAND 20852-3803



## Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 2673

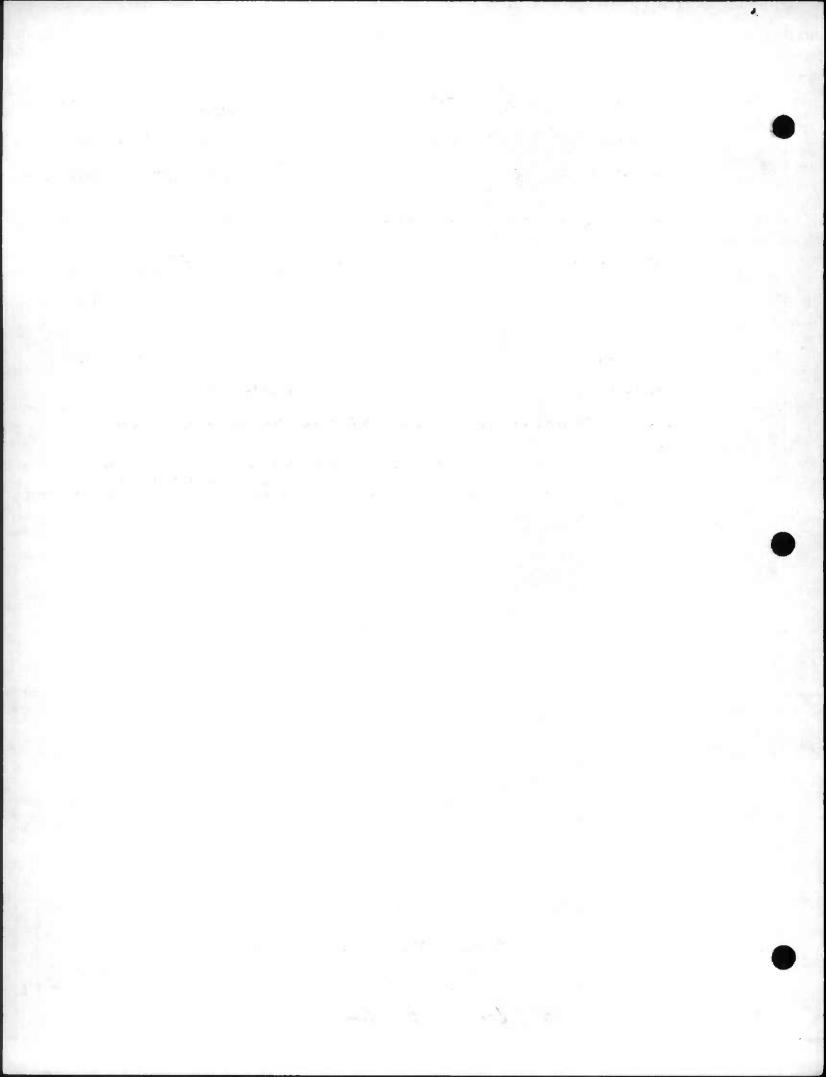
eral Director	Usual Residence of Dacedant  10a. State  10b. County  Maryland  Prince  10e. Street and Number  38 Orchard Towne  11. Marital Status  1 Never Married  3 Widowed 4 Divorced	Court Apri	61 10c. City,	St birthday) Yrs.  Town or Location  Laure 1  10f	nder 1 Yaar ths Days	4b. City, Town, or I aure 1 If Under 24 Hrs Hours Min	Location of Deat	Prince	George Ge	5:11PM  ge's se (State or Foreign ) ngton, D. C
ompleted by Funeral Director	38 Orchard Towne 5. Social Security Number 5. Social Security Number 6. S. 578-46-1408 Usual Residence of Dacedant 10a. State 10b. County  Maryland Prince 10e. Street and Number 38 Orchard Towne 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Court Apri George's  Court Apri George's  Court Apri 12. Was Decedent Armad Forcas? 1 \( \) Yes, Give	61 10c. City,	yrs. If Under Mon  Town or Location  Laurel	nder 1 Yaar ths Days	Laurel If Under 24 Hrs	B. Date of Bit (Month, De	Prince	George Ge	igton,D.C
by Funeral Director	5. Social Security Number 578-46-1408  Usual Residence of Dacedant 10a. State 10b. County  Maryland Prince 10e. Street and Number  38 Orchard Towne 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	George's  Court Apt  12. Was Decedent Armad Forcas? 1   Yes, Give	61 10c. City,	St birthday) Yrs.  Town or Location  Laure 1  10f	ths Days		. (Month, De		Washir	igton,D.C
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	15. Decedent's E	Year or Dates:		i. 13. Was D If Yes,	ecadent of H specify Cuba es 2X No	20707 lispanic Origin? (San, Mexican, Puer Spacify:	Specify Yes or No to Rican, atc.)	USA 14. Race Blace Specify	e - Amaricar k, White, etc : Whit	c.
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									-,	
-	Charles J. Keeth  19a. Informant's Neme/Relationship (			19b. Meiling Add	ress (Street	Mary J and Number or Fi	ane Long	erbeam er, City or Town,	State, Zip C	code)
	LIsa A. Verikios		O.A.)	38 Orcha	ard To	wne Cour	t. Apt.	102. Lau	rel. M	(D 20707
-	20a. Method of Disposition		20b. Pla	ace of Disposition metery, crematory	(Name of		Date	20c. Location -		
	1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			lawn Mem			8/20/09	Rockvil	In Mo	w1 a m d
8	21. Signature of Funeral Service Lice	nsee	μαικ	22. Nam	a and Addre	ss of Facility				гутано
	> Strank	Land P		Franc	is J.	Collins	Funeral	Home, ]	Inc.	
+	23a. Part1. Enter the diseasa, or com shock, or heart failure. List only	plications that cause	d the death.	Do not enter the	niver: mode of dyir	sity Blv	d., W., Si c or respiratory a	lver Spi	ring,M	D 20901 oproximate
	shock, or heart failure. List only									ntervel Between Onsat and Death
	Immediate Cause (Final disaase or condition	Mote	este	tic Su	mall	Lcoll	Plino	Camo	05	18 mond
	resulting in death)	a	Due to (or	es a consequence	of):		(	G-710		
							· ·			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events	b	Due to (or	es a consequence	of):				İ	
Г	Ceuse (Disease or injury that initieted events resulting in death) Last	C	Due to (or	as a consaquence	of):					
		d							1	
T	Part II. Other significant conditions of	contributing to death b	ut not rasul	ting In the underlyi	ing cause giv	en in Part I.	23b. Dld	tobacco uaa co	ntributa to t	he cause of death
1							12	Yes 2□ No	3 Probe	bly 4 Unknow
							24a. Was	s an eutopsy ormad?	avail	e autopsy findings lable prior to pletion of cause eath?
							1□	Yas 2 No	10	Yes 2□No
-	25. Wes case referred to medical					26. Place of De	eath (Check only			
3	examinar? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2   F	ER/Outpatient 3	DOA Oth			idence 6 □Oth	er (Specify)	
2	27. Manner of Death  1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Inju (Month, Da	Iry :	28b. Time of Injury	28c. Inju		*	how injury occur		
	3 Suicida 6 Could not be determined	200. Flace of In	ury - At hor c. (Specify)	me, farm, street, fa	ctory, office		28f. Location City or To	(Street and Numb own, State)	per or Rural i	Route Number,
		nysician: To the best miner: On the besis o and manner st	f examinetic							
100	29b. Signature end title of certifier				29c. Licans	se number		29d. Date signe	d (Month, D	ay, Year)
	, Ch	ehou	w !	mo	D	3322	_4	AUGU	T 17	, 1998
5	30. Name and address of person who	completed cause of c	leath (Item	23a) (Type, Print)	on ?	or Re	ckvic	LE M	par	1998



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month ANN KIBBELL 30 PM **Physician** GARAH AUG /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth Examiner HOSPINAL COLUMBIA MD HOWARD If Under 1 Year | If Under 24 Hrs. 8, Deta of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 200 F Director 579-20-6153 July 17, 1923 Washington, DC Usuel Residance of Dacedeni permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Dependentions of Health and Mentel Hygiane. Important: If item 27 is marked other than "natural; or items 23s or 28s-4 show any printy or other traumatic event, in Maryland Exercises must be notified at 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits 1□ Yas 2□No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 6336 Cedar Ln 21044 Funeral USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Giva Yaar or Detes: 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: PV Specify. White 3 € Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Doctor's Office 12 Bookkeeper 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) Kyle Marsh Gertrude Gibbons 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Steta, Zip Code) Charles A. Kibbey, Jr./Son 15109 McKnew Rd, Burtonsville, MD 21066 20b. Pleca of Disposition (Neme of cemetery, cremetory or othar place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Ramoval from Stete 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park | Aug 21 Rockville, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home alan 1 11800 New Hampshire Ave, Silver Spring, MD 20904 . Donnell 23e. Pert 1. Enter the disease) or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart felibra. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel RUPTURBO ABDOMINAL ADRTIC AUBURGEM HRS diseese or condition resulting in deeth) **Examiner** Due to (or es e consequance of) Examiner physicien and s the buriel-trensit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceusa (Disease or Injury that Initieted events rasulting in death) Lest Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequance of): 98 attending | signed by the at d be detached for Pert II. Other eignificant conditions contributing to deeth but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24a. Was en eutopsy performed? 24b. Ware eutopsy findings available prior to completion of cause of deeth? Completed certificata 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1, Dinpatiant 2 ER/Outpatient 3 DOA this funeral 28e. Date of Injury (Month, Dey Year) 27. Menger of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accidant i or Attand efter death Director: / by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Route Number, City or Town, Stete) 4 Homlcide To the Hospital o within 24 hours of To the Funeral DI completaly filled in Pelli 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier cai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) ene L Geligh MD D17502 0/18/98 10 COMMBIA 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 10802 HICKORY REUE'L GELBER MD RD RIDGE MD 21044 31. Dete filed (Month, Dey, Yeer) 32. Begistrer's Signature State 2 0 1998 Registrar



			Certifi	icate of L	Jeath		Reg.	No.	- low	017
<ol> <li>Decedent's Name (First, Middle, Las</li> </ol>	st)					2. Dete o		Dev	Yeer	3. Time of D
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le. Fecility Neme (If not institution, give	e street end number	)		4	b. City, Town,	or Location of I	Deeth	4c. County	of Deeth	
HOLY CROSS	HOSPITA	L			SILVE		ING	MOI	NTGO	MERY
5. Social Security Number 6. So	ex 7. A	ge (In yrs. last bi	Mo	Under 1 Year onths Days	If Under 24 H	in. 8. Date of	of Birth h, Dey, Ye	ar)	9. Birthp	plece (State or I
216-64-5159	ZXM 2DF	66	Yrs.			NOV.	.17,	1931		DIA
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		10c. City, Tow							1	Od. Inside City
MD. MONTGO	MERY		S	ILVER	SPRIN	G				1X Yes 2
I 0e. Street end Number			1	Of. Zip Code			10g.	Citizen of V	Whet Cour	ntry?
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1 Never Merried 2 Married	1 ☐ Yes 2 ②			Yes 2X No	Specify:		,			V.V.
3 Widowed 4 Divorcad	Year or Dates:				opouny.			Specify	AS	IAN
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Elementery/Secondary (0-12)	College (1-4or	5+)	life. DO N	VOT use retired,	)					
	4		TEL	EX OPE					I.M.	F.
17. Fether's Name (First, Middle, Last)					18. Mother's it	lame (First, Mi	ddle, Meid	en Sumen	10)	
К.	SAMU	EL			G	YANASU	INDA	RI	U	NKNOWN
19e. Informent's Neme/Reletionship (7	(ype, Print)	198	b. Melling Ad	ddress (Street e	and Number or	Rurel Route N	umber, Cit	y or Town,	Stete, Zip	Code)
ARVIND LEMU	EL/SON		SA	ME AS	ITE	M #10	)			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funarai Director: After this cartificate has been signed by the attending physician and completely filled in buthat uneard director name 2 should be deteched for use as the build-transit. the Funarai Diractor: Aftar this cartificata has been signed by the attending physician and mpletaly filled in by tha funeral director, paga 2 should be dateched for usa as the burial-transit Division of Vital Records, P.O. Box 68760, 5

**Physician** /Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Manyland Depertment of Health end Mantal Hygiana. Improciant: If item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat met mat be notified at

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

To

Examiner

Physician/Medical

Be Completed by

Medical Certification: To

29b. Signature end title of certifier

31. Date filed (Month, Day, Year) AUG 17

29c. License number D-2006 2

29d. Date signed (Month, Day, Year) Aug 151, 1998

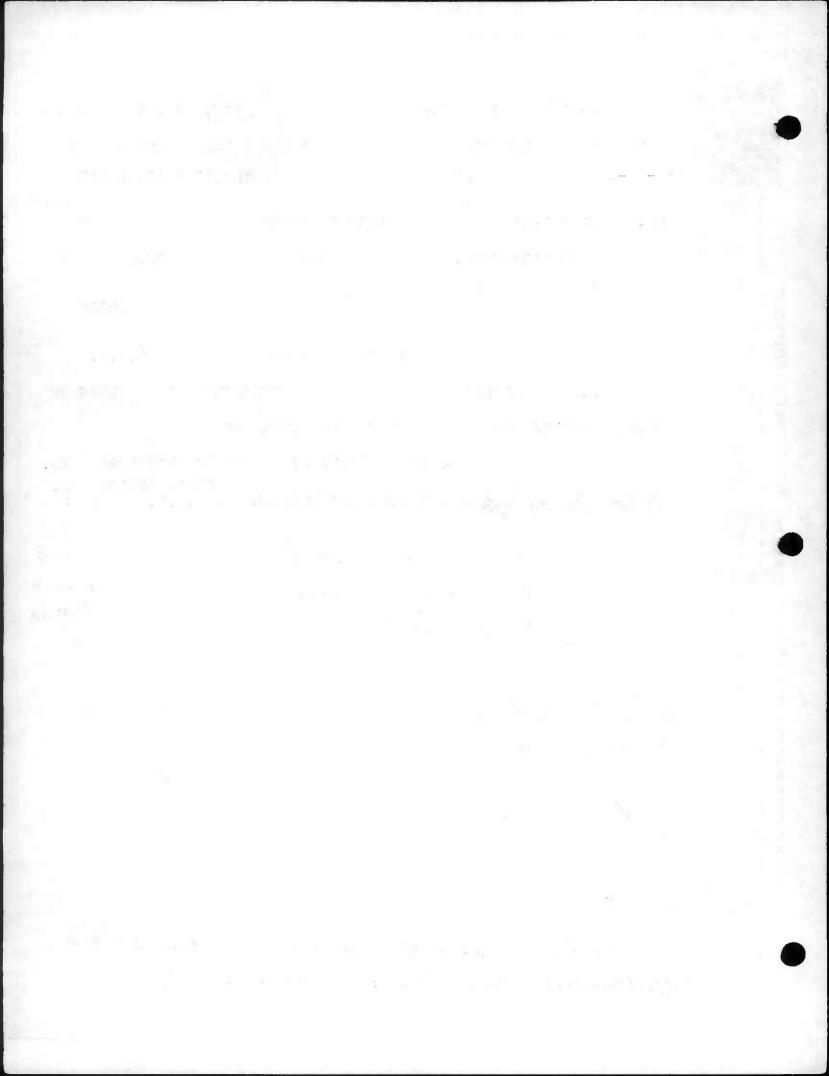
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print),

TONY P. KANNARKAT. 820/ 1610ST SILVERSPRING, MD 20910

State Registrar

820/16

32. Régistrer's Signeture parks



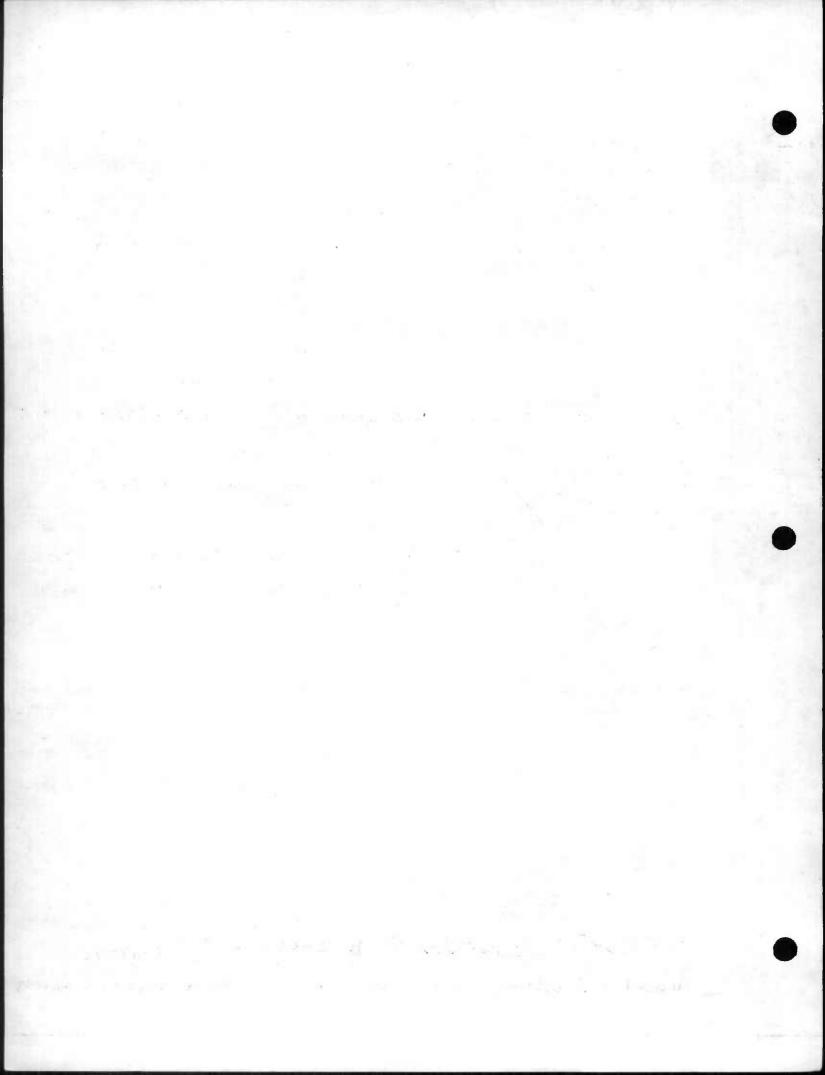
#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

SUSAN O. LEVY  AUGUST 16, 1998  AE Facility Name (if not institution, give street and number)  HOLY CROSS HOSPITAL  Funeral Director  Fune	nside City Limits ☐ Yes 2√ No
Social Security Number   Same (In of Institution, give street and number)   Same   S	ORK  nside City Limits  □ Yes 2√(I No
Director    Second   County	ORK  nside City Limits  □ Yes 2√(I No
10a. State   10b. County   10c. City, Town or Location   10d. Ir	Yes 20 No
18. Mother's Name (First, Middle, Maiden Sumame)  SOL GERSHON  19a. Informent's Neme/Relationship (Type, Print)  ALBERT D. LEVY (HUSBAND)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12722 TEABERRY ROAD — SILVER SPRING, MARYLA  20a. Method of Disposition  1 \( \text{Description} \)  20a. Method of Disposition  1 \( \text{Description} \)  20b. Place of Disposition (Name of cemetery, crematory or other place)  MT. LEBANON CEMETERY  22. Name end Address of Facility  DANZANSKY—GOLDBERG MEMORIAL CHAPELS, INC.  1170 ROCKVILLE PIKE — ROCKVILLE, MD. 20852  23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Application of the place of	
17. Father's Name (First, Middle, Last)  SOL GERSHON  19a. Informent's Neme/Relationship (Type, Print)  ALBERT D. LEVY (HUSBAND)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12722 TEABERRY ROAD — SILVER SPRING, MARYLA  20a. Method of Disposition  1	
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23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interiors.  Physician / Medical   Immediate Cause (Final disease or condition   CARDIAC ARREST - VENTRAL CHI AR FIRRAL ATTON.	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or beart failure. List only one cause on each line.  Physician  [Medical   Immediate Cause (Final disease or condition   CARDIAC ARREST - VENTRALIAR STRALIAR TON   CARDIAC ARREST - VENTRALIAR TON	
resulting in deathy	oroximate rval Between set and Death
Due to (or as a consequence of):  AORTIC VALVULAR HEART DISEASE  Due to (or as a consequence of):  AORTIC valvular HEART Disease  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	YEARS
	- 5
1 □ Yes 2 \ No 3 □ Probably	
performed? available complete	utopsy lindings le prior lo tion of cause 1?
To death    1   Yes   2   No   1   Yes	s 2 No
27. Manner of Death 1 Monattral 1 Monattra	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (Check only one)  29c. License number  29d. Date signed (Month, Day,	ıte Number,
290. Signature and title of certifier  290. Signature and title of certifier  290. Date signed (Month, Day, Day)  8-17-98	

State Registrar

ALbert H. GROLLMAN
31. Dete filed (Month, Day, Year) 32. Beg AUG 1 8 1998

10801 LOCKWOOD brive #200 S.S. Mb20900



# Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

				State o	of Marylan		artment rtificate		Health and Death	Mental Hy	/giene Reg. No.	3 2	6743
	Physici /Medio	al		lliam Lo					4b. City. Town, or	2. Date of D Month Augus	Day 19,	Year 1998	3. Tima of Death 5:38 Am
	Examir	er	4a Facility Nama (If not institution,	N HOUSE R					COLLEGE			ity of Death	GEORGES
	Funeral Director		5. Social Security Number 578–14–1864	6. Sex 1 M 2 □ F	7. Aga (In yrs. 77	last birthday) Yrs.	If Under 1 Months	Yaar Days		8. Data of B (Month, D	8. Data of Birth (Month, Day, Year) 9. Birthplace (Country) AUG. 10,1921 KENTUC		
	ehow alat		Usual Rasidanca of Dacedant  10a. Stata 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	ath with the Maryla 23a or 28a-f ehov	Director	MD. PRINC	CE GEORGE	S		COLL	EGE	PARK				1 🖾 Yas 2 🗆 No
	1 th	Die	10e. Street and Number				10f. Zip (	Code			10g. Citizen o	f What Cou	intry?
	ath v	rai		N HOUSE R					740			J.S.A.	
21215-0020	72 hours after death with the Manyand natural, or items 23s or 28s-f show deal Examiner mail or natified in	by Funeral	11. Marital Status  12 Nevar Married 2 Marrie  3 □ Widowed 4 □ Divorced	Armed Fo	2 🔯 No va		Vas Decede f Yas, speci i ☐ Yes 2		Hispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yas or N o Rican, atc.)	Spec	lack, Whita	ican Indian, , atc.
5-0	72 h	etec	15. Decedent' (Specify only highest	s Education t grada complated)		16a. Deced	lent's Usual kind of work	Occup	pation during most of wo	rkina	16b. Kind of	Business/li	ndustry
121	within ene.	Completed	Elementery/Secondary (0-12)	Collega (	1-4or 5+)	'life. I	DO NOT use	retire	d)			GTTT 1	
	Hygie ther t		17. Fathar's Name (First, Middle, L	5+			CHE	MT2.	18. Mother's Nar	na (First Middle	e Maiden Sum		ISTRY
Maryland	S a b >	o Be			LOAN S	R.			Q57E				A DIVIE
ary.	should ind Men imarke	2	19a. Informant's Name/Ralationsh		TOHIN D.	1	a Addrass	Street	and Number or Re	IOLA ural Route Numi	FRANCES ber. City or Tow		ARKE
Ž	ith ar		ROBERT H. COHE		-TN_T.AW					BELTSVII			
Baltimore,	Pages 1 ar		20a. Mathod of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (Sp	3 □Ramoval from	Stata 20b. P	lace of Dispo ematary, crem	sition (Name netory or oth	a of er pla	ce)	Data 8/24/98	20c. Locatio		own, Stata
Balt	permit. Departmimports eny inju		21. Signature of Funaral Sarvice L	icensee Meile	2 M000				ess of Facility FUNERAL P	IOMES,P.			LE, MD.2073
	Discolate a		23a. Part1. Enter tha diseasa, or c shock, or heart feilure. List of	complications that conly one cause on e	caused tha daath	h. Do not ant	ar tha moda	of dyi	ng, such as cardia	or respiratory	arrest,	1	Approximate Interval Between Onset end Death
	Physician /Medical Examiner		Immediata Ceusa (Final disease or condition resulting in death)	uR	INAR	Y B	LAD	D	ER (	TARCI	NO MA	9	Five years
		Jer	Tooling in doday		Dua to (o	r as a conseq	uence of):					1	
0,	i be axecuted siclan and bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaase or injury	b	Dua to (or	r as a conseq	uence of):					1	THE
Box 68760,	the death certificata be ax y the attending physician ached for use as the buna	n/Medicai	Causa (Disaase of Injury that initiated avants rasulting in daath) Last	d	Dua to (or	r as a conseq	uence of):				W.F	1	
). Be	death he atter	Physician/M	Part II. Other aignificant condition			ulting in the u	ndarlying ca	usa gir	ven in Part I.	23b. Did	i tobacco uae	contribute	to the cause of death
ls, P.O.	that ded b	by Phy	EMPHYSE	MA						1	Yes 2□ No	3 □ Pr	obably 4 Unknow
Record	aw requires been size should	Completed	CORPUL	MONA	LE.			_			s an autopsy formed?	a	Vere autopsy findings vailable prior to completion of causa of death?
E E	The ata h	Сод								1 🗆	Yes 2 No	1	□Yas 2□ No
on of Vital	Physician: Th this certificate ral director, pa	To Be	25. Was case referred to medical axaminar? 1 Yas You No	Hospital:	Inpatiant 2	ER/Outpatier	t 3 DO/	Ott	26. Place of Deher:	0.1	one)	Othar (Spec	ify)
o uoi	nding Ph ath. r: After th	ation:	27. Mennar of Death  1 SNatural 5 Pending 2 Accidant invastig		of Injury th, Day Year)	28b. Tima of Injury	M 28	c. Inju Wo	ryat rk?  Yes 2 □ No		how injury occ		

**Division** Medical Certification:

To the Hospital or Attending Phywithin 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

2 Medical Exampler: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) er: On the basis of axer and mannar stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tille of cartifier

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

ASIF S. CADRI, 4700 BERWYN HO COLLEGE PARK M) 20741 4700 BERWYN HOWSE 31. Data filed (Month, Day, Year)

State Registrar

AUG 2 0 1998

6 Could not be determined

3 Suicida

4 Homicide

32. Registrar's Signeture

and the second of Stationard Company of the The second secon 

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey August 12, 1998 16:50 Joseph A. Leighton 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth MONTGOMERY Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) if Under 1 Year 7. Age (In vrs. lest birthday) 6. Sex 1√2 M 2□ F Deys Hours Min. Months 85 JAMAÍCA July 23, 1913 042-26-4235 Usual Residenca of Deceden 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 9303 Avenel Road 20903 USA 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritei Status 1 Naver Married 2 Married 1 Yes 2 No if Yes, Give Year or Detes: 1 ☐ Yas 2 ₺ No Specify: Specify: BLACK 3 Widowed 4 Divorcad 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OPPERATIONS SUPPORT BANKING 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) IRVING A. LEIGHTON AMELIA JOHNSON 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type Print) 3616 DUNNINGTON RD. BELTSVILLE, MD 20705 JOHN LEIGHTON (SON) 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Birial 2 ☐ Cremetion 3 ☐ Removal from State PARK LAWN MEMORIAL PARK 8-17-98 ROCKVILLE, MD 4 ☐ Donetion 5 ☐ Other (Spacify) 22. Name end Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE 21. Storature of Fineral Service Licenses AVE. SILVER SPRING, MD 20904 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or haart failura. List only one cause or each line. Approximate Interval Batwaan Onset end Death Immediate Ceuse (Finel Slaphybroteal disease or condition rasulting in death) Du to (or es e consequenca of): dealysis Sequentially list conditions, if eny, leading to immediate causa. Entar Undarlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): rend ince Due to (or es e consequence Part II. Other eignificent conditione contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ishmi cardiomyopathy 24b. Were eutopsy findings eveileble prior fo completion of cause of deeth? 24e. Wes en eutopsy 1 Ves 2 The 1 □ Ves 2 □ No 26. Placa of Daeth (Chack only one) Hospital: 1 Hipatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? 1 Maturel injury 5 Pending Investigation 1 ☐ Yes 2 Accidant 3 Suicide

requires that the death certificate be axecuted burial-tran and physician P.O. Box 68760 the USB as for signed by Deen page 2 certificata Division of Vital I or Attending Physician: aftar death. Director: After this certifice director. funeral

24 hours a

To the Hospi within 24 hou To the Funer completaly fil

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Directo

Funeral

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Completed

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12

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permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mantal Hygiene.
Important if from 27 is marked other than "natural", or han any injury or other traument.

**Physician** /Medical

**Examiner** 

Examiner

Physician/Medical

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Completed

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Certification:

edical

Baltimore, Maryland 21215-0020

Brus

25. Was case rafarred to madical 1 Yes 2 No 27. Menner of Daath

4 Homlcide

29a. Cartifian

6 Could not be determined

28a. Place of injury - At homa, farm, streat, factory, offica building, etc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of cartifier Loser

29c. License number

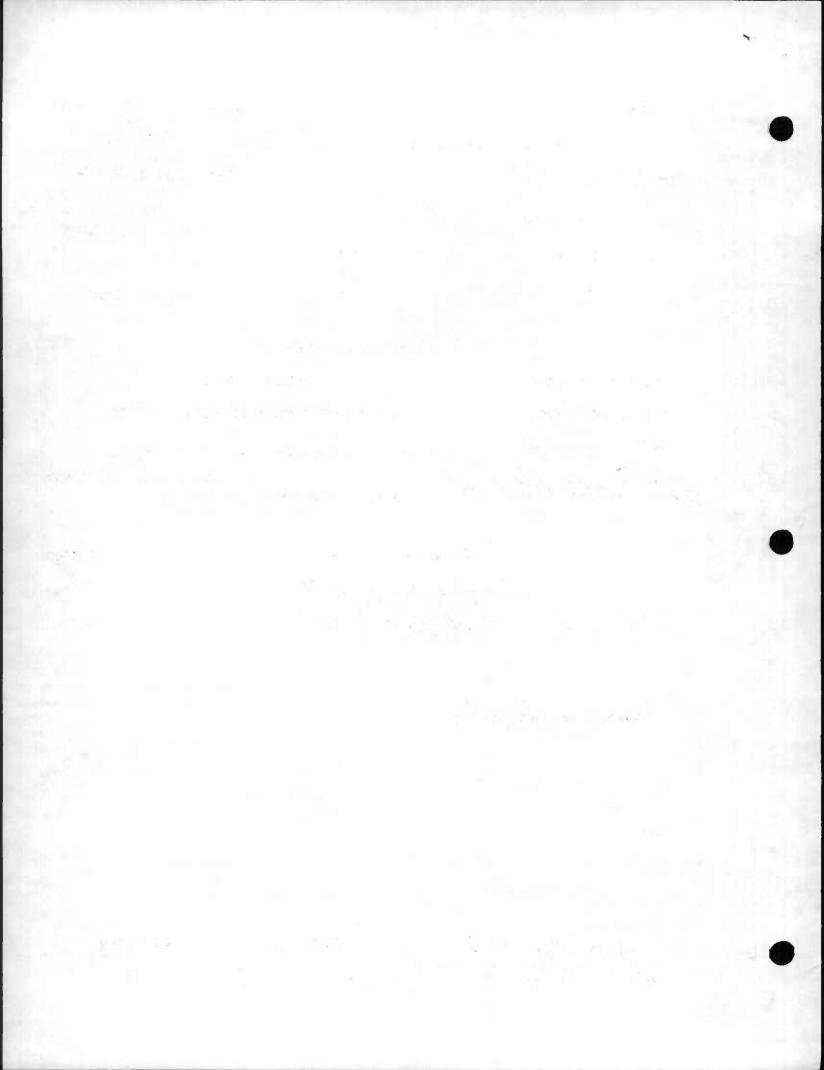
29d. Date signed (Month, Dey, Yeer)

30. Nama end addrass of parson who completed cause of death (item 23e) (Type, Print)

Kosen lar 10 31. Dete filed (Month, Day, Year) AUG 19

32. Registrer's Signature renewa

State Registra



## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth AWG **Physician** ON /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 Ø M 2 ☐ F 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** Months Deys Hours Min Yrs 83 Director N/A Mar 1, 1915 Korea Usual Residence of Decedent with the Maryland 10e Slate 10h County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? "naturel", or items 23s or 5505 Center St 20815 Korea Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Baca - American Indian 11. Marital Status Bleck, White, etc. 1 Naver Marriad 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify: à Oriental 3 → Widowed 4 Divorced Completed 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry then Elemantery/Secondary (0-12) Collage (1-4or 5+) Hygiane. 12 Pharmacist Pharmaceutical marked other 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Heart: If them 27 is marked oth ury or other traumatic aven Be Kang-Il Lee Yong-Ja Chung 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Jung Lee/Son 5505 Center St, Chevy Chase, MD 20815 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stele 1 Buriel 2 □ Cremetion 3 □ Removal from State permit. Page Department of Important: If any Injury or Choong Buk, Korea 4 ☐ Donelion 5 ☐ Other (Specify) Mongtani Ok-San Aug 24 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Hines-Rinaldi Funeral Home Bun 11800 New Hampshire Ave, Silver Spring, MD Donnell 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** Immediate Causa (Final M YO C ARDIAL

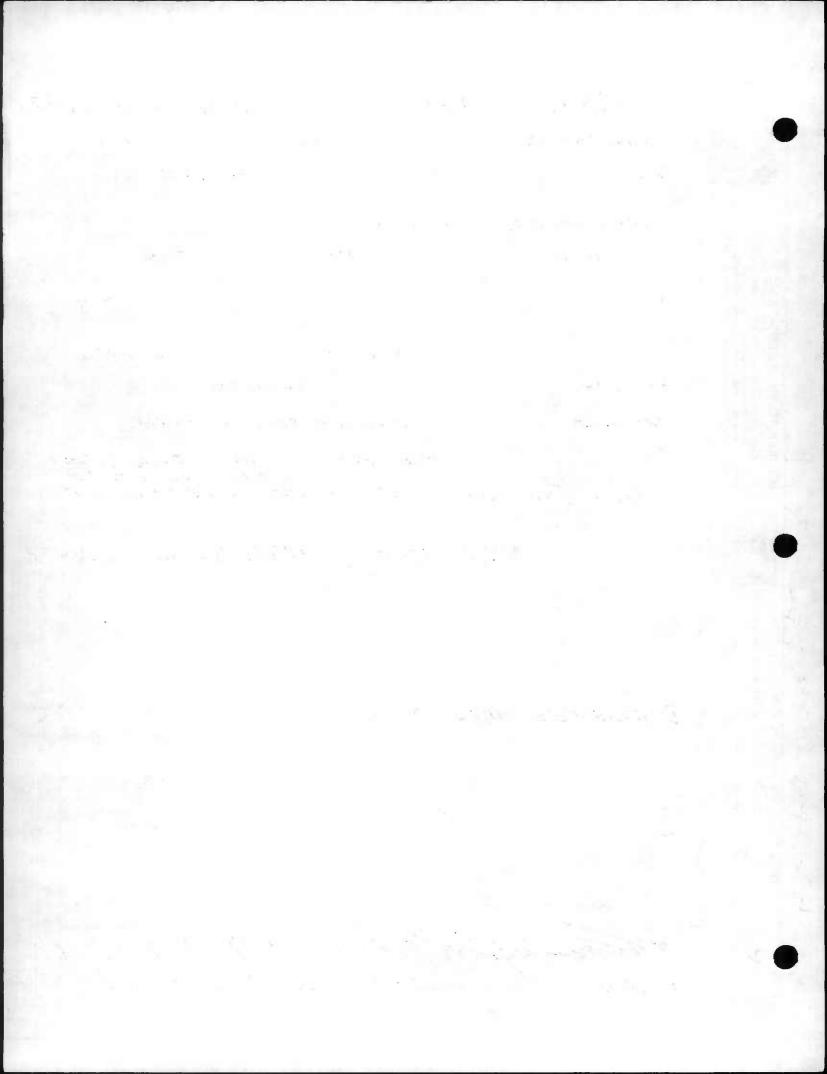
Due to (or es e consequence of): INFARCTION diseesa or condition rasulting in daath) Examiner Examiner the daath certificate be axecuted Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burial Physician/Medicai Due to (or as a consequence of): attending ph Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS à 24b. Ware eutopsy findings eveilable prior to completion of cause of daeth? Completed 24a. Wes an eutopsy performed? page 2 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No After this cartificate Hospital or Attending Physician: 25. Was case referred to medical examinar?

10 Yes 2 No Be 26. Piece of Daeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No 2 Accident ofter deat 6 Could not be datermined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homloida 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner es steted.

2 Hedicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) d causa of deeth (Item 23a) (Type, Print) 30. Nema end eddrass of person who comp FRN WOOD RANCES 31. Data filed (Month, Day, Year) 32. Registrer's Signature State AUG 1 9 1998 enera Registrar

8-17-8

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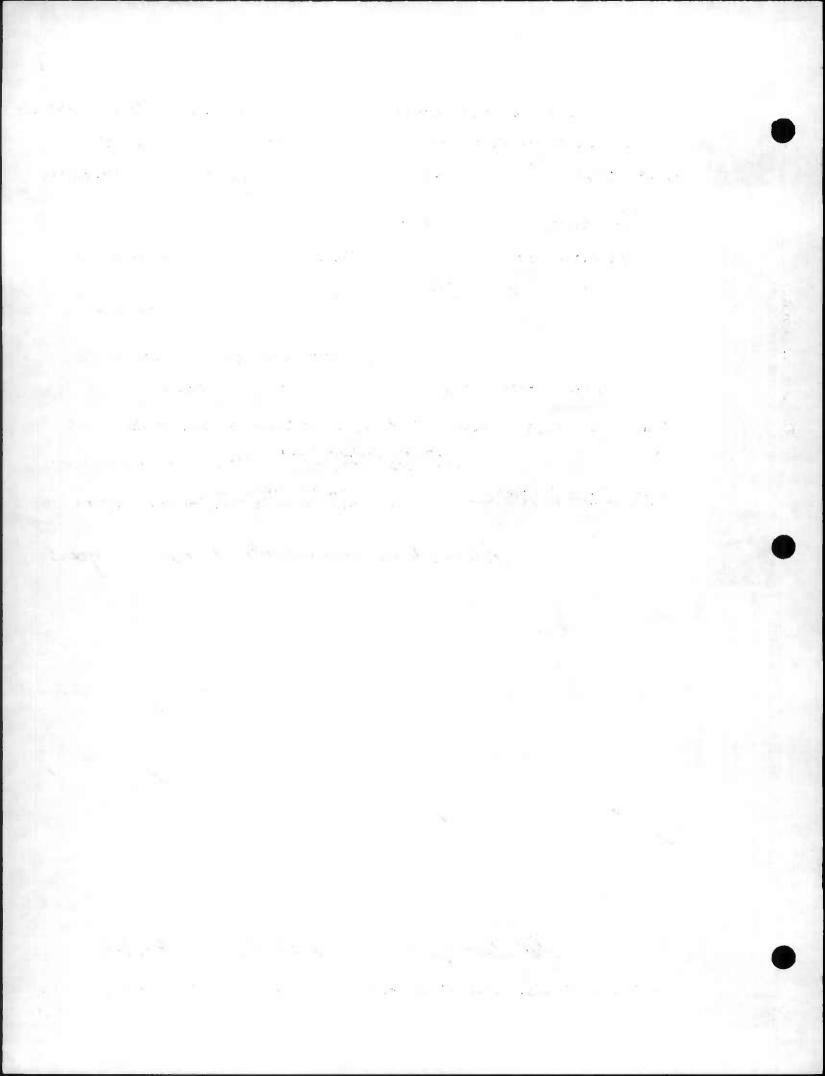
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 14; 1998 August 4:22 AM Edward Raymond Lohmeyer /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** The Memorial Hospital Easton Talbot 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Birthpiace (Stete or Foreign Country) **Funeral** Min. Months Days 1 X 2 F Hours Director 48 March 27, 1950 216-54-5853 Maryland Usuel Residence of Decedent filed within 72 hours efter deeth with the Maryland 10a. State 10d. Insida City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Talbot Easton 10a. Citizen of What Country? 10e. Street and Numbar 10f. Zip Code 9218 High Banks Drive 21601 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 TYPES 2 No 1970
If Yas, Give 1974 14. Race - American Indien, Black, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Edward Lohmeyer altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify. P Year or Detes: 1974 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 12 Shipping/Receiving Manager Manufacturing 7 is marked other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be end Mental William Lohmeyer P Charles Peggy Bradshaw 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Haalth ( permit. Pages 1 and Department of Haalth Important: If item 27 any Injury or other tr page. Bonnie Lee Lohmeyer Wife 9218 High Banks Drive, Easton, Maryland 21601 20b. Placa of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Maryland Eastern Shore 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) 8/18/98 Beulah, Maryland Veterans' Cemetery 21. Signature of Funeral Service Licansee 22. Name and Address of Facility PMare Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 23a. Part<sup>1</sup>. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician Atheroscherofic cardiovascular disease /Medical Immediate Cause (Final years disease or condition rasulting In daath) Examiner Examiner physician and s tha burief-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Records, P.O. Box 68760 Physician/Medical Due to (or as e consequenca of) attending p signed by the ai Part II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobecco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was en eutopsy Completed performed' ate has b 2 No 1 ☐ Yes 2 Z No is certificate b 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I Be 25. Wes case raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Data of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be datarmined 28a. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida 12 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar es stated.

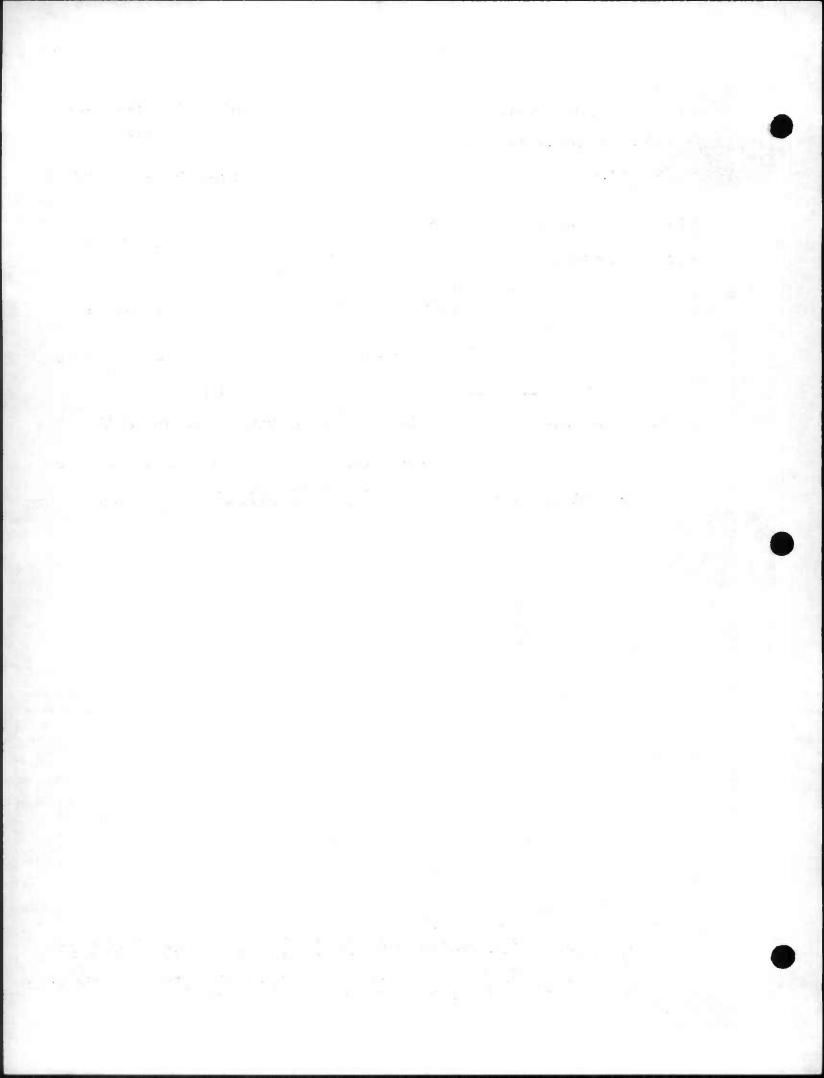
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Cartifiar 29d. Dete signed (Month, Dey, Year) 29c. License number 29b. Signature and title of cartifier 30. Name and address of person who completed causa of daath (Item 23a) (Type, Print) Michael D. Crowley, M.D., 508 Idlewild Avenue, Easton, Maryland 21601 31. Data filed (Month, Day, Year) 32. Registrer's Signature State Registrar



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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day **Physician** 5:05 AM August 12 1998 Gladys F. Mellov /Medical 4b. City. Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Sacred Heart Home, Inc. Prince Georges Hvattsville If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Deys 1□M 280 F Months Yrs. 577-07-9522 81 Oct. 24, 1916 Idaho Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 No Maryland Prince Georges Directo Hyatsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5805 Queens Chapel Rd. 20782 U.S.A 8 Funer 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 M No tf Yes, Give Year or Deles: 14. Rece - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) U.S Government Payroll Supervisor 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Unobtainalbe Unobtainable 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Thomas Melloy /son 1416 SE 21st Ave., Cape Coral, Florida 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Meadowlawn Memorial Gardens 8/19/98 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) New Port Richey, FL 22. Name and Address of Fecility of Funeral Service Licansee Joseph Gawler's Sons INC., 5130 Wisconsin Ave. NW Washington, DC 20016 ie, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Finel disease or condition resulting in death) 5 Weeks Cardiac Arrythmia Due to (or es a consequence of): Examiner Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown COPD by 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Completed completion of cause of deeth? 1 Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of fnjury 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical 2 Medical Examiner: On the basis of examination end/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aug. 13, 1998 D19609 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

10810 Darnestown Rd. #202, Gaithersburg, MD 20878

Sparke

State Registra

Tuli MD.,

32. Registrar's Signature

Raman R.

**Funeral** 

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

with the Meryland

**Physician** 

Examiner

/Medical

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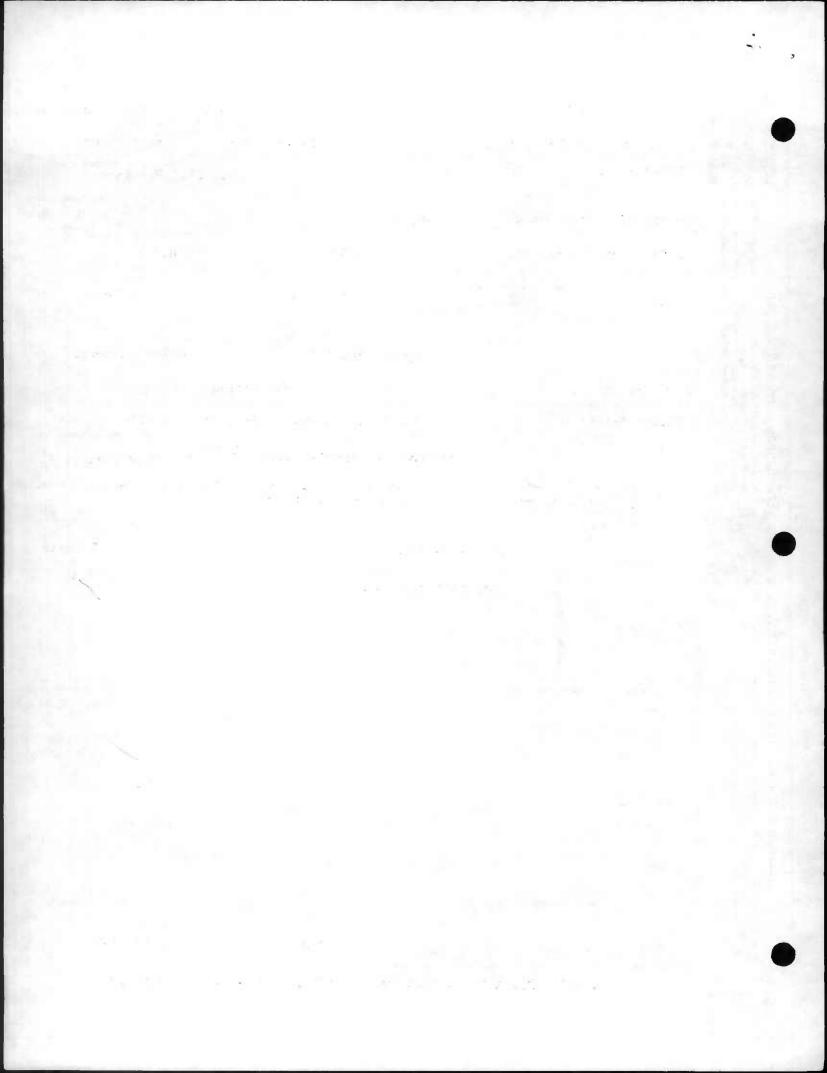
Box 68760.

P.O.

Records,

Division of Vital

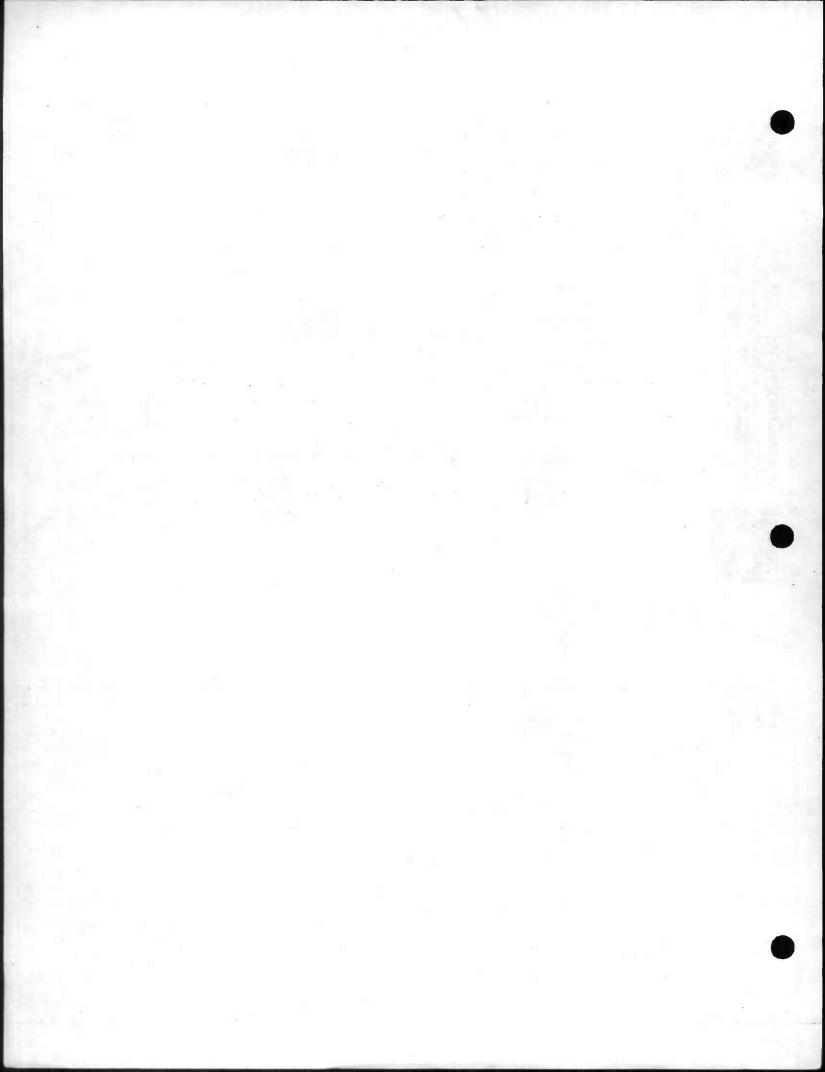
Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

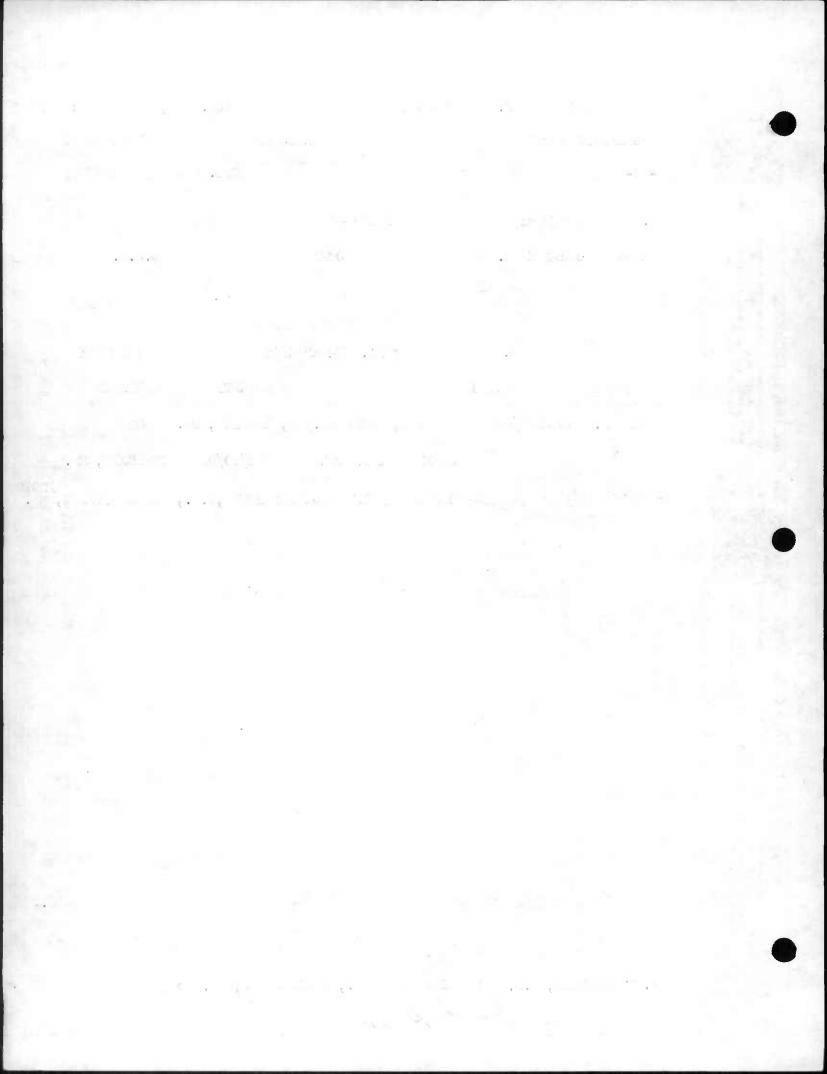
			Cei	rtificate of	Death	F	leg. No.	20/50					
Physician	1. Decedent's Neme (First, Middle, La Frances P. Milt		- 1346			2. Date of Dea Month August	th Dey 199	3. Time of Death					
/Medical Examiner	4e Fecility Neme (If not institution, gir Montgomery Gener	e street and number)			4b. City, Town, or L Olney		4c. County	of Death					
Funeral Director	210-01-1200	Sex 1	: last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey Feb 28,	Year) 1914	Birthplaca (State or Fore Country)     PA					
be notified at	Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Lim					
la-fai filled ctor	MD Montgom	ery S	Silver	Spring				1 □ Yes 2 ℃					
Here 23e or 25e-f shoulder at the matches at the ma	100. Street and Number 15100 Interlache	n Dr #104		10f. Zip Code 2090	)6		10g. Citizen of W USA	/hat Country?					
by F	11. Meritel Stetus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Detes:		Was Decedent of H If Yes, specify Cubi 1 ☐ Yes 2 <sup>1</sup> No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Blac	A-American Indien, k, White, etc.					
ygiene. er than 'netur it, the Medical Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occup kind of work done	during most of worl	king	16b. Kind of Bu	siness/Industry					
omp den	Elementery/Secondery (0-12)	College (1-4or 5+)	Teacl	DO NOT use retired her	3)	1	PA Publ	ic Schools					
Mental Hyg info event, I To Be C	17. Father's Neme (First, Middle, Last Aaron Plittman	)			18. Mother's Nam		Maiden Sumem						
and in man	19e. Informent's Name/Reletionship		19b. Meilir	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Code)					
m 27 her tr	Harry J. Milton-	4			hen Dr #			ng ,MD 20906					
ant: if its	20e. Method of Disposition  1 🖾 Burial 2 Cremetion 3 C  4 Donetion 5 Other (Speci	Removal from State	cemetery, crer	sition (Name of metory or other plea emorial G	Gardens 8		Olney,	City or Town, Stete  MD					
Department Important: any injury once.	22. Name and Address of Fecility Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike Rockville MD 20852												
hysician /Medical xaminer	23a. Pert1. Enlar the diseese, or comshock, or heart feilure. List only times to condition resulting in deeth)	e. PNEUMONI						Interval Between Onset and Deeth					
as been signed by the attending physician end a 2 should be datached for use as the bunial-transit npieted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	c	or as a consequence or as a consequence		2001	COMIA							
d by the attandir latached for use Physician/A	Pert II. Other significant conditions of	contributing to death but not re	sulting in the u	nderlying cause giv	ren in Pert I.	23b. Did to		tribute to the cause of de					
igned by be data						101	es 20 No	3 Probably 4 Unkr					
cate has been signed by the page 2 should be datached Completed by Physic				365		24a. Wes o		24b. Were autopsy finding evailable prior to completion of cause of deeth?					
peg CO						1 D Y	es 20 No	1 ☐ Yes 2 ☐ No					
certificate irector, per	25. Wes case referred to medical examiner?	Hospitel:		100	26. Place of Dee	th (Check only or	ne)						
S D	1 Yes 2 No	12 Inpatient 2L	28b. Time of		4 LI Nuising H	ome 5 Resid							
al Director: After the in by the funers  Certification:	1 Neturel 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be	e Discontinue Att	Injury	M 1	k?" Yes 2 □ No			er or Rurel Route Number,					
urs after ral Direction by	4 Homicide determined	building, etc. (Spec	ify)			City or Tow	n, Stete)						
within 24 hours after death. To the Funeral Director: After the complately filled in by the funeral Medical Certification:	(Check only 2 Medical Examone)	ysician: To the best of my kn niner: On the basis of examin end manner steted.	owledge, death ation end/or inv	vestigation, in my o	pinion, deeth occur	red et the time, o	late end place, e	end due to the cause(s)					
10 10	29b. Signeture end title of certifier  Cultic gyer	pul M.j		29c. Licens	AND D	12452 1	TUSUST S	1 (Month, Day, Year) SIXTEENTH 1998					
	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, オ32子,	Print) DR. C OLNGY	HITRA I	20832	PAZ, M.	).					
State Registrar	31. Dete filed (Month, Dey, Year) AUG 18199	32. Megistrar's Sign	eture $\mathcal{G}$ .	Spark	1								



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ 25751

			Certificate of	Death	Reg. No.	0/01
· PANON BRANCO AND	1. Decedent's Name (First, Middle, Las	)		2. Dete Mont	of Death	3. Time of Deeth
Physician /Medical	KATHE	J. M	ACKOUR		JG. 18, 1998	1:45 PM
Examiner	4a Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location of	Death 4c. County of Deeth	
	AUXILIARY HOU	SE		BETHESDA	MONTGO	MERY
Funeral Director	452-44-0401	7. Age (In yrs.)	last birthday) If Under 1 Year Months Days	Hours Min. (Mon	th, Dey, Year) Count	ece (State or Foreign ry) RMANY
9 3	Usuat Residence of Decedent  10a. State  10b. County	10c. Cih	y, Town or Location		10	d. Inside City Limits
with the Maryland a or 28s-f show the notified at Director	MD. MONTGON		BETHESDA			1 X Yes 2 No
arr with the Mi 123e or 23e-f. suit be notifie	10e. Street and Number		10f, Zip Code		10g. Citizen of What Count	ry?
eff. v			208		U.S.A.	
-0020 hours after death v hurst', or thems 23s at Examinar must	3 (X Widowed 4 □ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	S. 13. Wes Decedent of the fixes, specify Cub  1 ☐ Yes 2 ☑ No	dispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et Specify:	c.) Bleck, White, e	
72 ho	15. Decedent's Edu	cation	16a. Decedent's Usual Occu (Give kind of work done	pation	16b. Kind of Business/Inde	ustry
1 21215-0020 ad within 72 hours at yourse than 'nestural', or it, the Medical Exam Completed by 1	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ARMACIST	PHARMA	NOV
		<del>*</del> †	ADDI. FIL	18. Mother's Name (First, A		ICI
yland wid be file whether thy whether other afte event.		MECKAUER		MARGARETI		ď
A Maria	19a, Informant's Name/Relationship (T		19b. Mailing Address (Street		Number, City or Town, State, Zip	-
Me 27 Pe		COUR/SON	1517 HILL R	D.#6C, READING	PA 10609	
Pages 1 a ent of Her II hem ry or othe	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 6	20b. P	lace of Disposition (Name of emetery, cremetory or other pla	Date	20c. Location - City or Tov	vn, State
E and the second	4 Donation 5 Other (Specify,		AMBERS CREMATO	RY 8/20/	98 RIVERDALE	, MD.
Departiment of the popular of the po	23a. Pert1. Enter the disease, or compshock, or heart failure. List only of	rleis @ MOO	22. Name and Address  O91 CHAMBERS  Do not enter the mode of dyi	FUNERAL HOMES	P.A., SILVER SI tory errest,	20910 PRING, MD. Approximate Intervel Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	confest	Ve Pror ras a consequence of;	+ frihe	les destable	Onset and Death
deeth certificate be executed estanding physician and ad for use as the buriel-transit	Cause (Disease or injury that initiated events resulting in death) Last	с	r as a consequence of):		V K C I PV I D	
BOX	Part II. Other significant conditions co	ntributing to death but not may	iting in the underlying cause oi	ion in Bod I 23h	. Did tobacco use contributa to	the cause of death?
15, P.O. BOX res that the deeth ce ligned by the estandle the deteched for use by Physician/		l Age	and grant and underlying cause gr	VOIT IN POIL 1.		ably 4 Unknown
ew requi		8		24a	performed? eva	re eutopsy findings illable prior to appletion of cause leeth?
Con Pege Pege Pege Pege Pege Pege Pege Peg					1 Yes 2 Ho 1	Yes 2□ No
Vital I	25. Was case referred to medicat			26. Place of Deeth (Check	only one)	
- K D		Hospital: 1   Inpatient 2	ER/Outpatient 3 DOA	her: 4 Nursing Home 5	Residence 6 Other (Specify	)
Jon Of ding Phy th.: Afterthi funeral	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury Mo	ny at rk?  Yes 2 □No	cribe how injury occurred	
Division of the Hospital or Attending Physician 24 hours efter death. To the Funeral Director. After the completely filled in by the funeral Medical Certification:		28e. Place of Injury - At he building, etc. (Specify	me, farm, street, lactory, office		ition (Street end Number or Rural or Town, Stete)	Route Number,
he Hospi in 24 hour he Funer pletely fill	29a. Certifier 1 Certifying Phy check only one) 1 Medical Exami				to the cause(s) end menner es sto time, date and place, and due to	
Withir To the comp	29b. Signature and little of certifler	7 12	29c. Licens		29d. Date signed (Month, E	Dey, Year)
6	10000C	Hold	) 139	5456	AUG-19,1	1998
	30. Name and address of person who co		23a) (Type, Print) SCONSIN AVE., (	CHEVY CHASE. M	Barrier Marie	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signa				



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ()

	Certificate of Death  Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Dete of Deeth Month Dev	3. Time of Deeth
Physician /Medica	RAYMOND MAZUREK Aug 18 1	998 4:30 p.m.
Examine	to English Name (If not leatifuling of peets of Deets to County	ty of Deeth
W		gomery
Funeral Director	5. Social Security Number  149–24–9662  Usual Residence of Decedent  6. Sex 12M 2 F 62  7. Age (In yrs. lest birthday)  62 Yrs.  FUnder 1 Year If Under 24 Hrs. Months Deys Hours Min.  12 Hours Min.  12 Hours Min.  12 -17-35	9. Birthplece (State or Foreign Country)  New York
Maryland H show	10a. Slete 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2X No
death with the Maryland ms 23s or 28s-f show mast be notified at	2141 Rayen Tower Ct. # 301 20170 United	Whet Country? d States
urs after al', or its	Armed Forces?  1 Never Married 2 Merried  1 Never Married 2 Merried  1 Yes, specify Cuben, Mexican, Puèrlo Rican, etc.)  1 Yes, specify Cuben, Mexican, Puèrlo Rican, etc.)  1 Yes, specify Cuben, Mexican, Puèrlo Rican, etc.)  1 Yes 2 No Specify:  Specify Cuben, Mexican, Puèrlo Rican, etc.)	ace - American Indien, eck, White, etc. White
han 'natur e Medical	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)	Business/Industry
ther the		
ked o	Edward Mazurek  Olga Pisk	
S ma	19e. Informent's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town	
n 27	Nina Mazurek - Wife 2141 Raven Tower Ct. Herndon, Virg	
ant: If Nen ury or oth	cemetery, cremetory or other place)	gton, Va.
Departi Import any Inj pnce.	21. Signeture Funeral Service Licensee 22. Name end Address of Fecility Arlington Funeral Service Licensee 3901 N. Fairfax Dr. Arlington,	
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.	Approximete Intervel Between Onset end Death
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)  e. CANCER OF LUNG	Chool and Dodin
	Due to (or es e consequence of):	
ician and burial-transit	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	
phi s	Due to (or es e consequence of):	
attendin for use	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  WETASTASIS TO RIB AND SKIN  23b. Did tobacco use of the state of th	
the a	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contributions.	contribute to the cause of death?
	METASTASIS TO RIB AND SKIN  ÀXY•• 2□ No	3 Probably 4 Unknown
	24a. Was en eutopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of deeth?
ate ha	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No
artific actor	25. Was case referred to medical examiner?	
10	examiner?  1 Yes 2 No  Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 DO  27. Manner of Death  28e. Dete of Injury  28b. Time of 28c. Injury et 28d. Describe how injury occi	
seath. Iort Atlar the fund	1X Natural 5 Pending (Month, Dey Year) Injury Work? 2 Accident investigation investigation M 1 Yes 2 No	
a Funeral detaly filled	29a. Certifier (Check only one)  Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and recommendation of the cause of my knowledge, deeth occurred et the time, date end place end my noner stated.	menner es stated. e, end due to the cause(s)
To the think		ned (Month, Day, Year)
10	30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)	1/9/1998
	Elliot R. Goldstein 9410 Old Georgetown Rd. Bethesda, Maryland 20	814
State Registra	0110 0 4 4000 1	

The man break g in a series in the series of the and the same it produces and other and the same that the same and A Comment of the comm 

by Funeral Director	1. Decedent's Name (First, Middle  J.  4a. Fecility Name (If not institution, SHADY GROVE  5. Social Security Number  520-24-1278  Usuel Residence of Decedent  10a. State 10b. County  MD. MONTG(  10e. Street and Number  9 HUTTON  11. Marital Status  1 Never Married 2 Marrie  1. Never Marri	JOSEPH give street end number) ADVENTIST 6. Sex 1 MM 2 D F 7. Age	68 (In yrs. lest birt	TAL  hday) If Under 1 Yea  Months Day:	ROCKV	8. Date of Birth (Month, Dey,		GOMERY
by Funeral Director	SHADY GROVE  5. Social Security Number  520-24-1278  Usuel Residence of Decedent  10a. Slate  10b. County  MD.  MONTGO  10e. Street and Number  9 HUTTON  11. Marital Stalus	ADVENTIST 6. Sex 1 MM 2 F 7. Age	68 (In yrs. lest birt	hday) If Under 1 Yea Months Days	ROCKV	S. 8. Date of Birth (Month, Dey,	MONT	GOMERY
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by Funeral Director	Usuel Residence of Decedent  10a. Slate  10b. County  MD • MONTG  10e. Street and Number  9 HUTTON  11. Marital Stalus	DMERY	10c. City, Town	Yrs.		TITINE OF	Yeer)	<ol> <li>Birthplace (State or Foreig Country)</li> </ol>
by Funeral	MD. MONTG  10e. Street and Number  9 HUTTON  11. Marital Stalus			or Location		JUNE 24	1930	WYOMING
by Funeral	10e. Street and Number  9 HUTTON  11. Marital Status		(					10d. Inside City Limit
by Funeral	9 HUTTON 11. Marital Stalus	СШ		GATTHERSBUF	RG			1 ▼ Yes 2 N
by	11. Marital Status	CITI		10f. Zip Code		10	g. Citizen of W	het Country?
þ		12. Was Decedeni E	ever in U.S.		20877 Hispanic Origin? (	Specify Ves or No-		S.A American Indian,
V	3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒️No		rto Rican, etc.)		, While, etc.
l et	15. Decedent' (Specify only highes	's Education t grede completed)		Decedent's Usual Occi (Give kind of work don	upation e during most of we	orkina 1	6b. Kind of Bus	
Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT use retir	red)		TODIA	AFTON
Be Co	17. Fether's Name (First, Middle, L	ast)		TEACHER-AL		me (First, Middle, M		ATION
ToB	JOHN	J. McINT	YRE SR.		BI	EULAH	NIXON	
1	19e. Informent's Name/Relationsh		19b.	Mailing Address (Street	et and Number or R	lural Route Number,	City or Town, S	itete, Zip Code)
	NANCY F. McIN  20a. Method of Disposition	TYRE/WIFE	20b. Place of	SAME AS Disposition (Neme of	ITEM #10		Oc. Location - (	City or Town, State
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemeter	y, cremetory or other places CREMAT		8/15/98		
	21. Signature of Funeral Service L		CITALL	22. Name and Add		0/1)/90	VIAEV	DALE, MD.
	12/11/1	Exmberte	M00091	CHAMBERS	FUNERAL.	HOMES PA	STLVE	20910 R SPRING, MD.
al Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Ceuse (Disease or injury	· Parof	( Kne	consequence of):	I flut lecem	ter		5 mont
Physician/Medical	that initiated events resulting in death) Lesi Pert II. Other eignificent condition	d	Due lo (or as a co		given In Part I.	23b. Did tob	_/	ribute to the cause of death
Completed by						24a. Wes en perform		24b. Were autopsy findings evailable prior to completion of ceuse of deeth?
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	30. Name and eddress of person w	tho completed cause of de	ath (Item 23a) (	Type, Print)	()		7	40/1 /7/ (10
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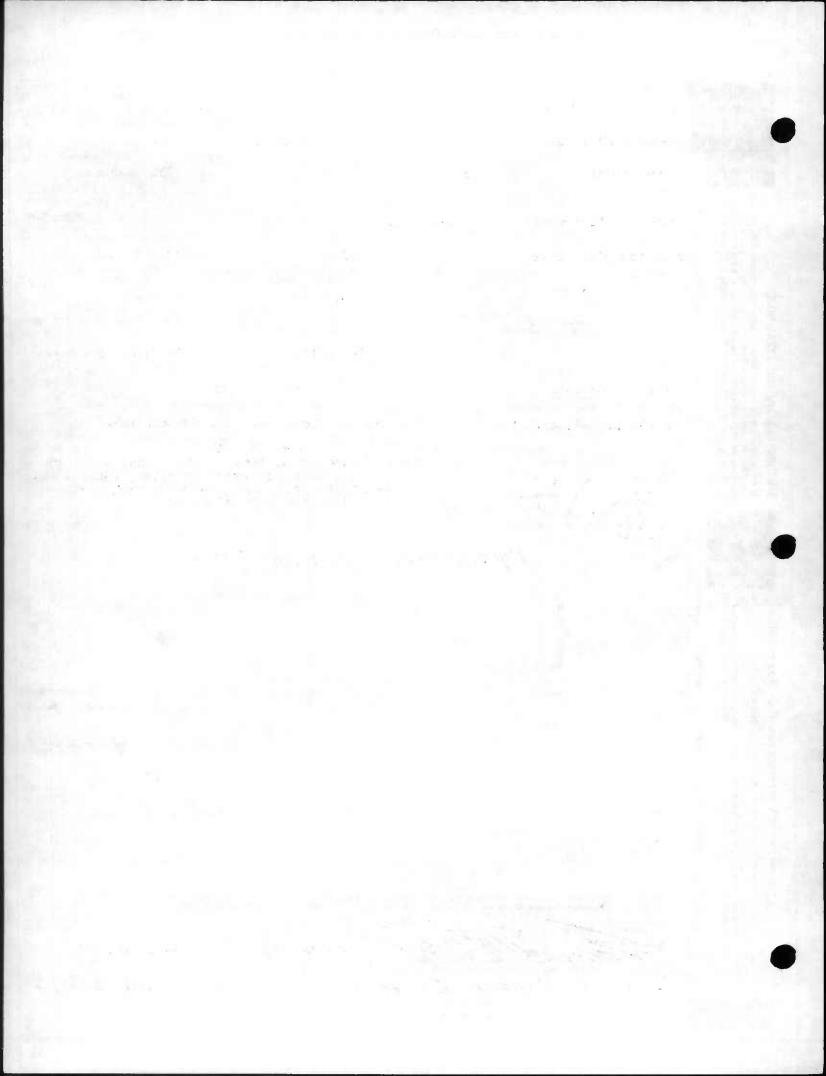
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State of Maryland / Department of Health and Mental Hygiene 98 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Robert Earl Mellott 16, 1998 August 11:16 PM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7 Scotch Mist Court Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 18, 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 15 M 2□ F 509-30-2021 63 Yrs. Kansas **Director** Usual Residence of Decedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1KI Yes 2 No Director Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 7 Scotch Mist Court United States 20854 Funeral filed within 72 hours efter deeth 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 0 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Etementary/Secondary (0-12) College (1-4or 5+) Hyglene. Business Management Consultant other permit. Pages 1 and 2 should be file Deperment of Health and Mantal Hy Important: If item 27 Is marked other any injury or other traumatic event, bloss. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Earl L. Mellott Elva Burgat 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 7 Scotch Mist Court, Rockville, Maryland 20854 Kathy L. Mellott/Wife 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) August 19, 1998 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00689 or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest List only one cause on each line. Source Approximate fntervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical INFARCTION MYOCHRDIAL Examiner Due to (or as a consequence of): Physician/Medical Examiner attending physician end for use as the burial-transit The law requires that the death certificete be executed Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Box 68760. that Initieted events resulting in death) Last Due to (or as a consequence of) signed by the a 23b. Dld tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evallable prior to completion of cause of death? should I 24a. Was en eutopsy performed? Completed After this certificate has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: efter death. Director: After this certifice Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 10 1 XYes 2 No funerel 28d. Describe how injury occurred 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident To the Hospital C. Within 24 hours effer death
To the Funeral Director: 6 ☐ Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai (Check only one) and menner stated. 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifie 29c. License number August 18, 1998 30. Name and address of person who completed cause of death (nam z.sa) (Type, Frint) BETHESDA MD 20817 10213 RNWOO RANCIS 31. Date filed (Month, Day, Year) 32. Registrer's Signature

Registrar

AUG 1 9 1998



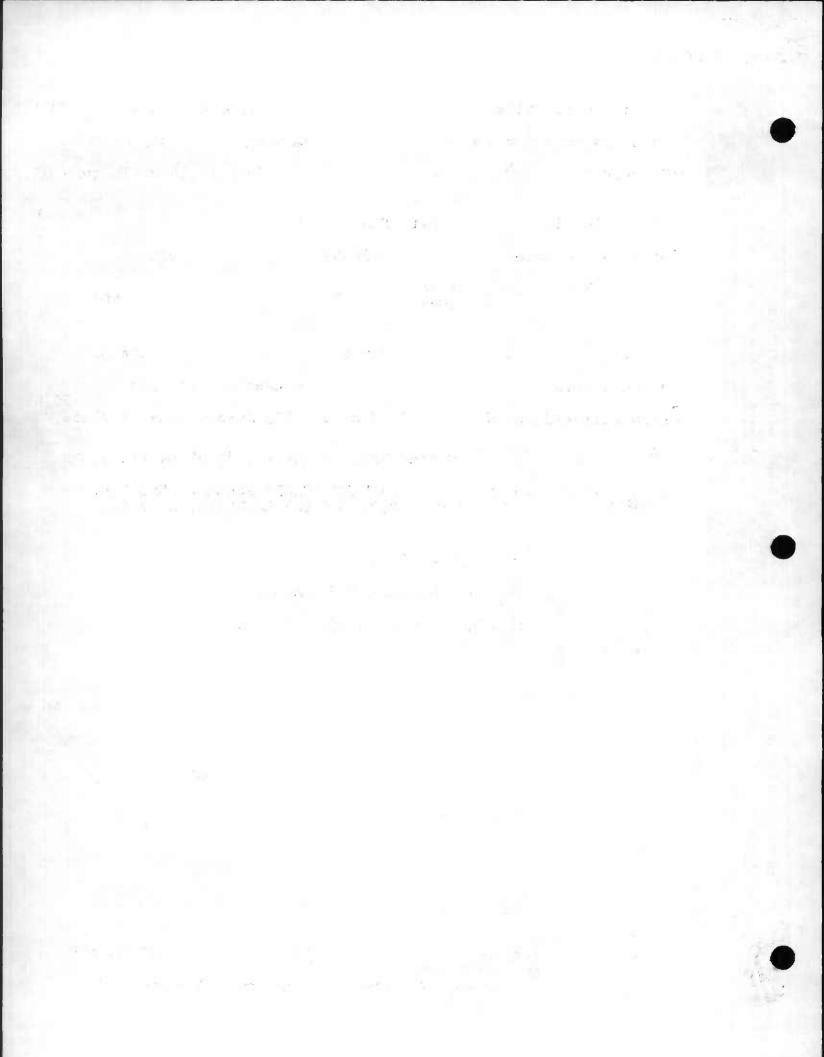
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State of Maryland / Department of Health and Mental Hygiene

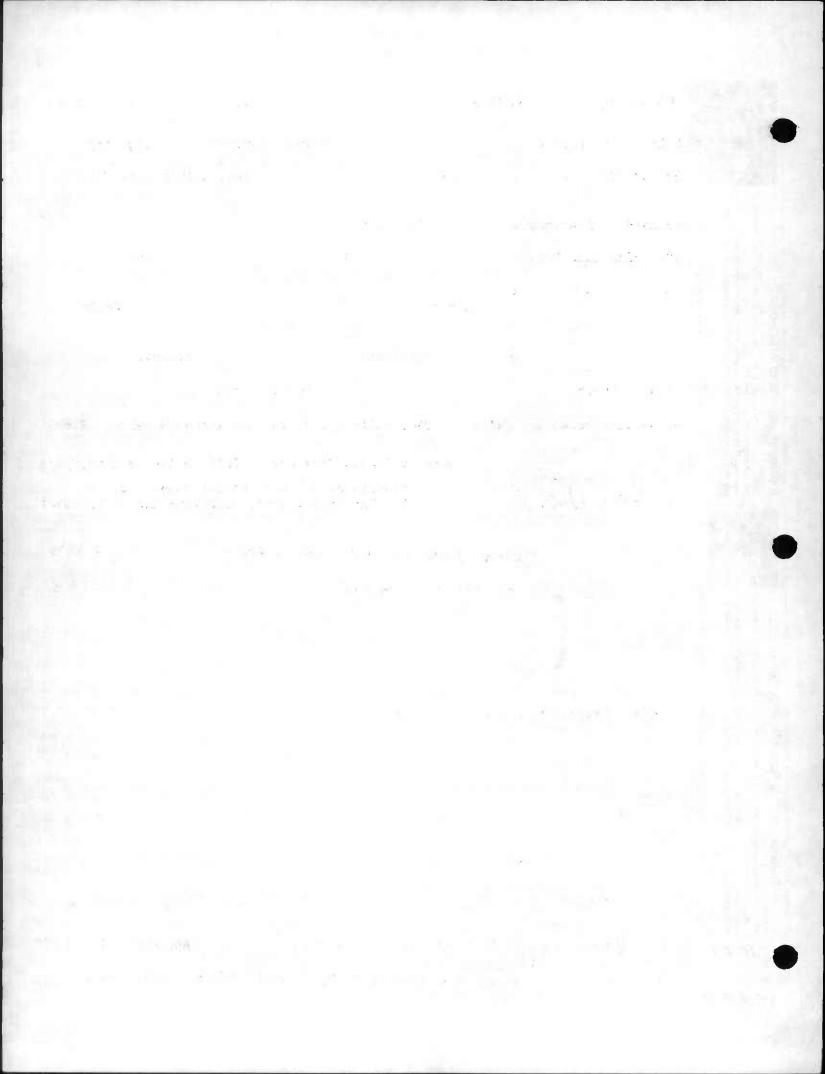
Certificate of Death

Bear No.

26757

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Pe		15. Decedent	's Education		16e. Dece	dent's Usuei O	ccupation	n			16b. Kind	of Business/	
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or other		Cremation	3 Removal from	State		metory or other	r plece)			Dete		tion - City or	
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fica	3 Suicide	6 ☐ Could n	ot be	e of Injury - A	At home, farm, st	reet, fectory, of	fice		28	f. Location	(Street end	Number or R	ural Route Number,
e T	4 Homicide	dotomin	build	ding, etc. (Sp	pecity)					City or To	wn, State)		
edicai C	29a. Certifier (Check only one)		Physician: To the team men										
completely filled in by the fune Medical Certification	29b. Signature end	d title of certifier	011011101	inor oracios.		29c. Li	cense nu	umber			29d. Dete	signed (Moni	th, Dey, Year)
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98-28758Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death AUGUST 17, 1998 3:10 PM OFFUTT CHARLES 4b. City, Town, or Location of Death 4a Facility Neme (II not institution, give street end number) 4c. County of Death MONTGOMERY Gaithersburg Mediplex of Montgomery Village If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Hours 100 M 2 F 78 215-12-7898 Oct.8, 1919 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 28 No Montgomery Gaithersburg 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 17060 King James Way, #613 20879 U.S.A. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Detes: 1 Nevar Married 2 Married Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Laborer Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Herbert Offutt Elizabeth Carter 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 8200 Warfield Rd., Gaithersburg, MD 20882 Robert Campbell (Step-son) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ⊠Buriel 2 □ Cremation 3 □ Removel from Steta 8/20/98 Sandy Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) Ash Memorial Cem. of Funeral Service License 22. Neme and Address of Fecility SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or as a consequence of): Q on crent Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest 1/0) 4 Dua to (or as a consequence of) rans diaser Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably MUnknown 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2.00 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Yes 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Baltimore, Maryland 21215-0020 **Physician** /Medical Examiner

Examine

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Medical

1 ☐ Yes 2 Ne

27. Menner of Deeth

1 Netural

2 Accident

3 Suicide

29a. Certifier

JOHA

4 Homicide

290. Signature and title of certifian

31 Date filed (Month, Dey, Year)

**Physician** 

/Medical

**Examiner** 

10a. Stete

MD

6th

**Funeral** 

Director

or 28a-f show

234

Hema:

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or itel important: if Item 27 Is marked other than "natural", or itel any Injury or other traumatic event, or the fact of Exercities once.

the Medical Examiner must be nothing at

Director

Funeral

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Completed

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Box 68760, Physician/Medical Completed Be Certification: To É Attor

P.O. Records, Division of Vital Attending after death Director: To the Hospital of within 24 hours at To the Funeral Discompletely Illed I

> State Registrar

AUG 1 9 1998

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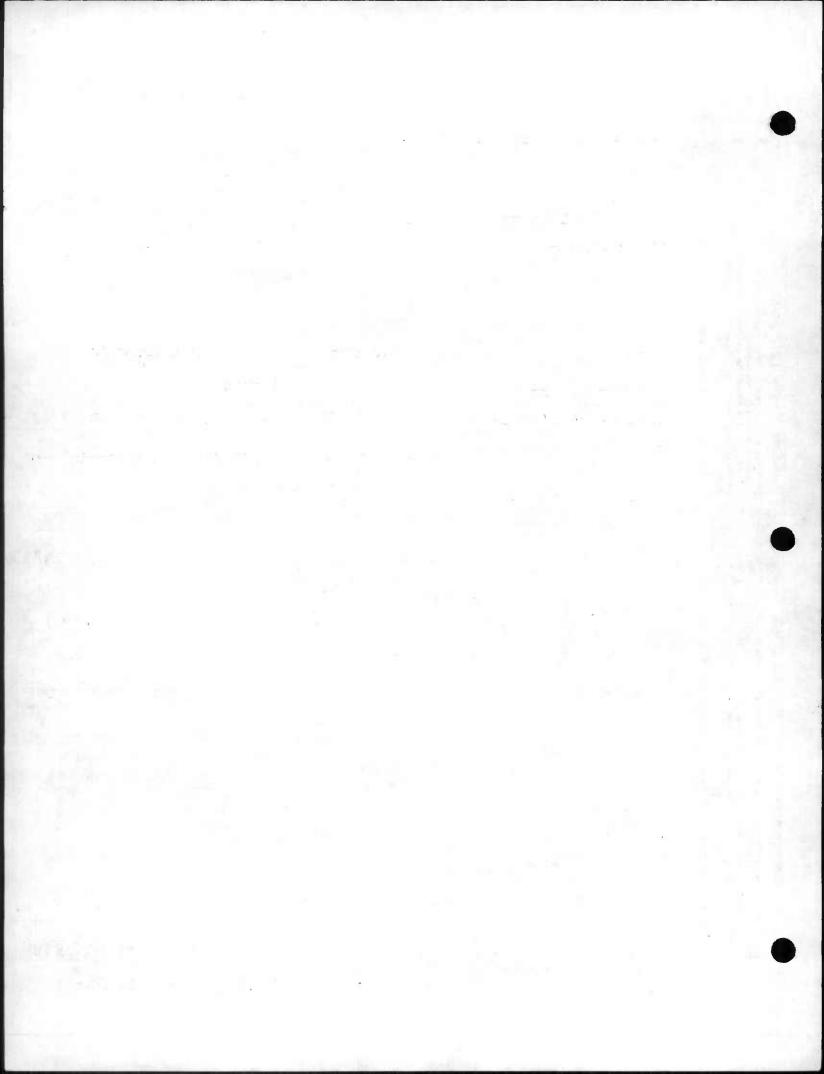
ddress of person who completed cause of death (Item 23a) (Type, Print) 911 32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

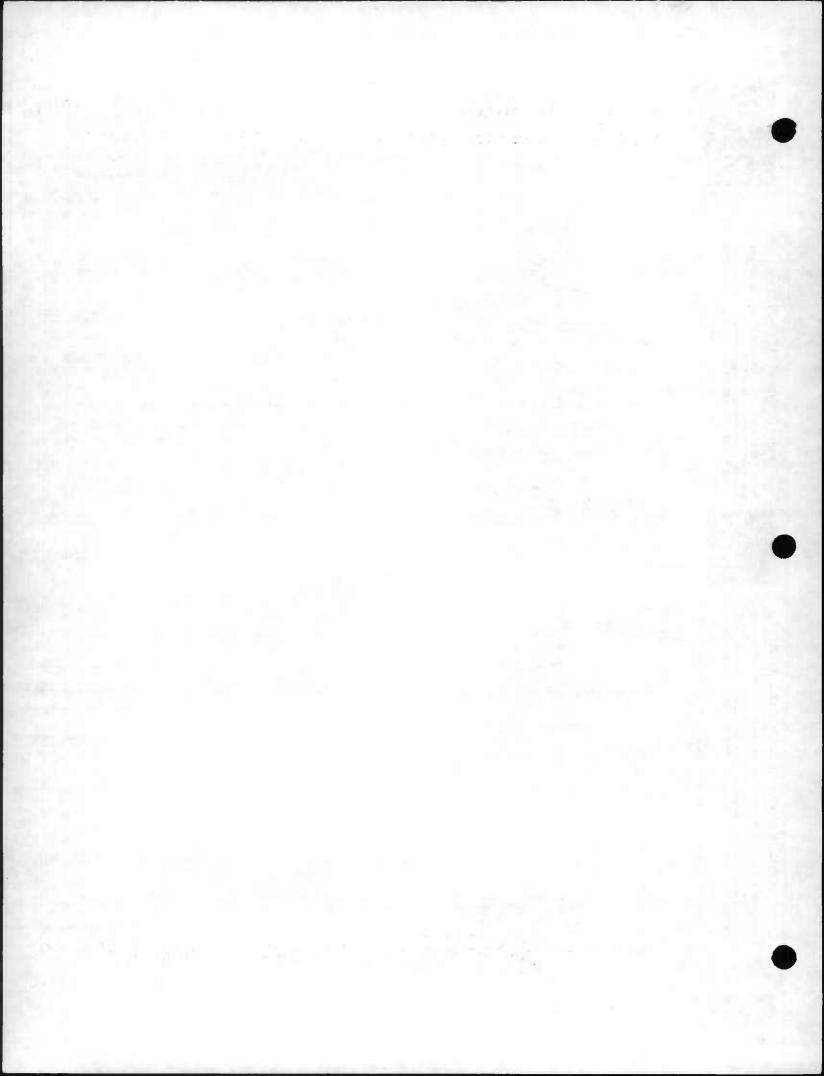
29c. License number

29d. Date signed (Month, Day, Year)



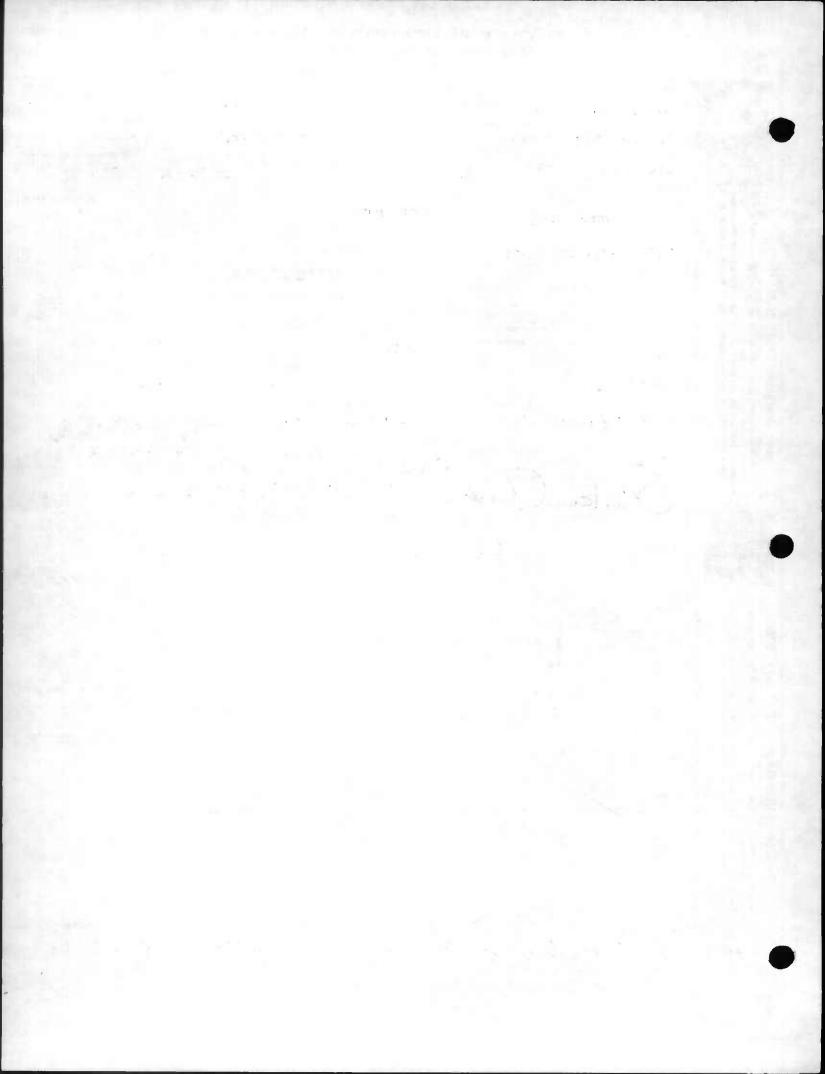
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Parker Avavst 1998 Thornas W. /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (St. Country) | April 24, 1930 | Georgia 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1⊠ M 2□ F Yrs. 225-36-9148 68 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exeminar must be notified at 1 X Yes 2 □ No Directo Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6700 Olde Mill Court 20855 USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on of Heelih and Mental hygiene.
In: If item 27 is marked other than "natural", or item iny or other traumatic event, the Medical Exertine iny or other traumatic event, the Medical Exertine. 1 Tyes 2 No
If Yes, Give
Year or Dates: 1948-52 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Thomas W. Parker Helen Bender 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Myrtle Parker (wife) 6700 Olde Mill Court, Rockville, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State permit. Page Depertment of Important: If any injury or page. Metropolitan Crematory 8/16/98 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Service Licenses 500 University Blvd. West Home, Inc. Silver Spring, MD 20901 | SIIVET SPITING, FID 20301 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Dysrythmia minutes Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction 6 days that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): 88 USB 50 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? thed signed by the Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes an eutopsy peen completion of ceuse of death? hes page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Wes case referred to medicel examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) J. 1 ☐ Yes 2 No this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: or Attanding Patter death. After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funerel Dis completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es steted.

2 Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 16 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, MD Tammy Tadem, M.b. 20850 31. Date filed (Month, Day, Year) AUG 18 1998 32 Registrar's Signeture State



State of Maryland / Department of Health and Mental Hygiene 98 26760

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	Examiner	4e Fecility Name (	in not institution, gr enilworth		mber)				Garrett			nty of Deetl	
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	f show	10a. State	10b. County  Montgome	erv		y, Town or Local arrett ]							10d. Inside City Limits  X□ Yes 2 □ No
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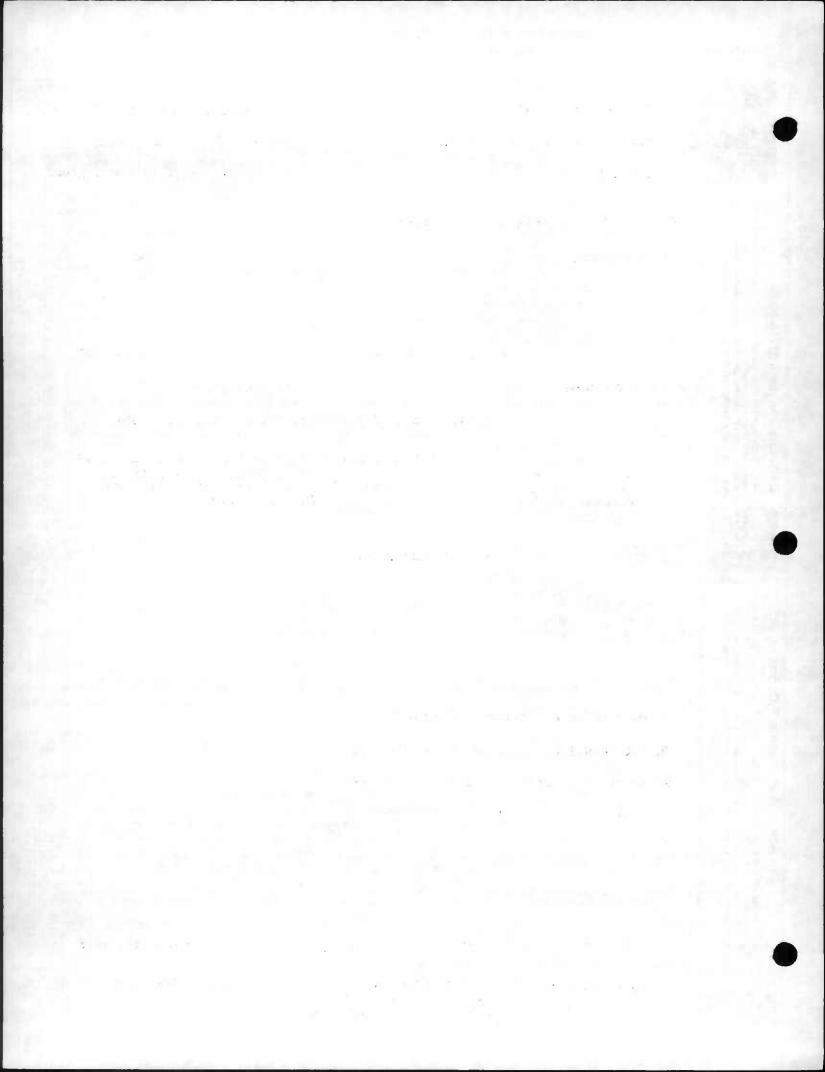
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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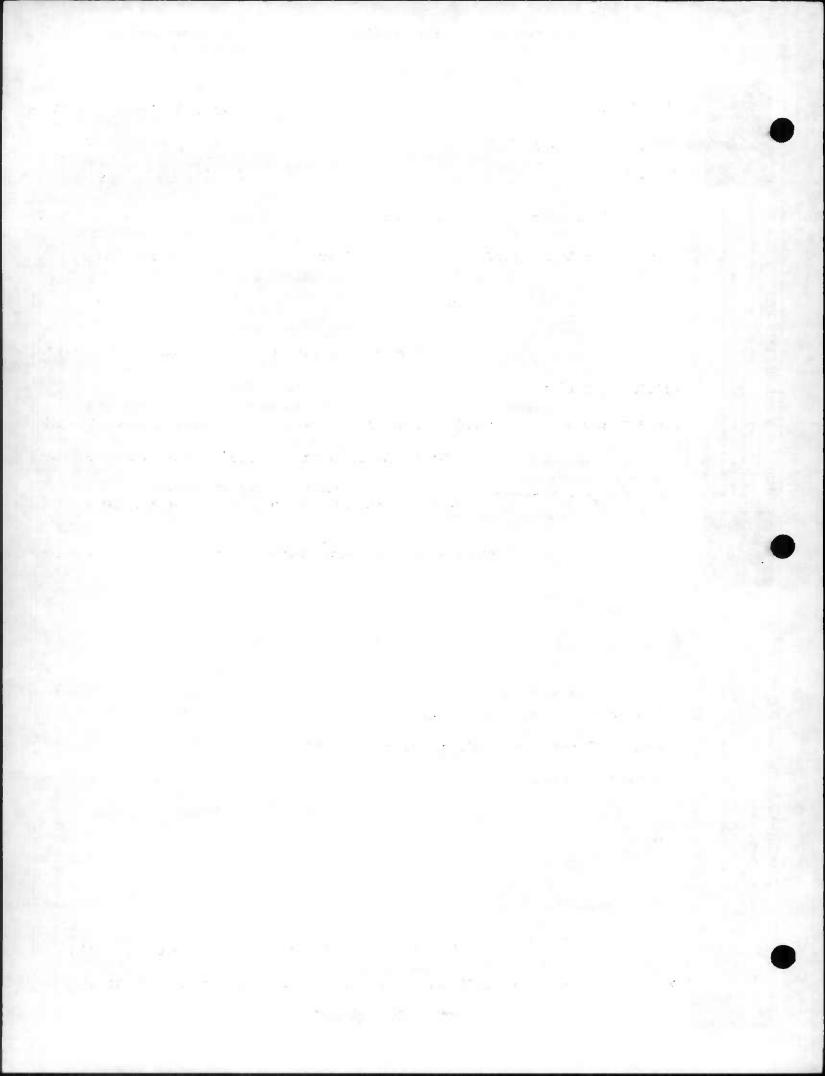
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State of Maryland / Department of Health and Mental Hygiene 98 26762

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CONSTANCE	V		Pu	MPHRE	4			August	Dey /7, /9	Yeer 198	19:25
e. Fecility Neme (If not institution, giv	e street end number	9r)	, ,	and live		b. City, Tov	vn, or Lo	ocation of Deeth	4c. County		. [. 2 ]
Suburban Hospit			lion			Beth				tgom	erv
. Sociel Security Number 6. S		Age (In yrs. la		) If Under 1		if Under 2	4 Hrs.	8 Date of Righ			piece (State or Foreign htry)
579-20-2694	□M 2∏F	76	Yrs.	Months	Deys	Hours	Min.	July 23,	1922	Cour Wash:	ington, DC
Jsuel Residence of Decedent								, , ,			,
0a. State 10b. County		10c. City	, Town or L	ocation						1	0d. Inside City Limits
MD Montgom	nery	В	ethes	da							1 ☐ Yes 2 ☑ No
0e. Street end Number				10f. Zip C	Code			10	g. Citizen of \	Whet Coul	ntry?
10250 Westlake Dr	ive, #61	3		20	081	7			U	SA	
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1 Never Merried 2 ☐ Married	1 ☐ Yes 2 [ If Yes, Give			1 ☐ Yes 2		Specify:	. 00.10	1110011, 010.			etc.
3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:		,00 20	Z	Speedig.			Specify	Wh:	ite
15. Decedent's Ed (Specify only highest gre	ducation ade completed)		16a. Dece	edent's Usuel ( e kind of work DO NOT use	Occupa done	ation luring most	of work	ing 10	6b. Kind of Bi	usiness/In	dustry
Elementary/Secondery (0-12)	College (1-4d	or 5+)									
12			Vi	ce Pre	sid		1. (:		Riggs		
7. Fether's Neme (First, Middle, Last)								e (First, Middle, Ma		10)	
Howard Pumphrey						1	Mabe	l Shaffe	r		
19e. Informent's Neme/Reletionship (	Type, Print)		19b. Mail	ling Address (S	Street	and Number	r or Run	el Route Number,	City or Town,	Stete, Zip	Code)
William Hoag	(nephew					ow Dr	ive,	Gaither	sburg,	MD	20878
0e. Method of Disposition 12D Burial 2 □ Cremetion 3 □	Removel from Ste	00	ece of Disp metery, cre	oosition (Neme emetory or oth	of erplec	e)		Dete 20	c. Location -	City or To	own, State
4 Donetion 5 Other (Specifi			ar Hi	11 Cem	ete	ry	8	3/21/98 S	uitlan	d, M	D
21. Signature of Funeral Service Licen	1560		2	22. Name end	Addres		Fr	ancis J.	Colli	ns F	uneral
Maburt 2K	amser	1		Home,				iversity	Blvd.	Wes	t
23e. Pert1. Enter the diseese, or company shock, or heart feilure. List only	plicetions thet can	d the death.	Do not er	Silver	of dyln	g, such es o	ardiac	20901 or respiretory erres	st,		Approximete
snock, or heart feilure. List only	one ceuse on eag	line.								į	Intervel Between Onset end Deeth
mmediete Ceuse (Finel	CORON	rand	Do		1	20.000	-			H.	30 years
esulting in deeth)	e. Corcorc	3375 10 10	96 9 cones	equence of):	ي ا	-3CN3	6				100
		246 10 (01	05 0 001156	equation of.						1	
Sequentially list constitues	b. ———	Due to for	96 3 CODES	equence of):	-						
Sequentially list conditions, flany, leading to immediate cause. Enter Underlying		Due 10 (01	05 a 001150	rquentos orj.						!	
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^					ise give	m m Pen. i.					
PNEUMONIA								1,50,100	2 🗆 No	3 Pro	bably 4 Unknow
PNEUMONIA CHRONIC OBSTRU		1		Λ				24e. Wes en	eutopsy		ere eutopsy findings
CHRONIC OBSTRU	CTIVE 1	Lunon	MRY	LESEN	130	-		perform	ed?	CO	elleble prior to mpletion of cause
									. Pless		deeth?
								1 □ Yes		11	Yes 28 No
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1 Neturel 5 ☐ Pending		Day Year)	28b. Time o Injury		work	(?	lo l	28d. Describe hov	injury occur	ieu	
2 Accident investigation 3 Suicide 6 Could not be		hadana da da		M		Yes 2□N	10	not Leasting (C)	natanal Ation 1		A Courte Atomit
4 ☐ HomicIde determined	286. PIECE OF	Injury - At hor etc. (Specify)		treet, fectory, o	OTTICE			28f. Location (Stre City or Town,	State)	er of Hur	rioute Number,
					17000		-				
(Check only 2 Medicat Exam	niner: On the basis	of examinetic						end due to the cau red et the time, dat			
one)	end manner	steted.									
9b. Signature end title of certifier						number 242	2		d. Dete signe 1		
	The state of the s				7 7	47	5		Jugust	11	1000

20854

The Baltimore, Maryland 21215-0020 **Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, Its Medical Examines must be notified at

Directo

Funeral

þ

Completed

Be 2

Examiner

Physician/Medical

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Completed

Be 2

Medical Certification:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit

State Registrar

B. Robert MOZAYENI 31. Date filed (Month, Day, Year) AUG 2 0 1998

30. Name end eddress of person

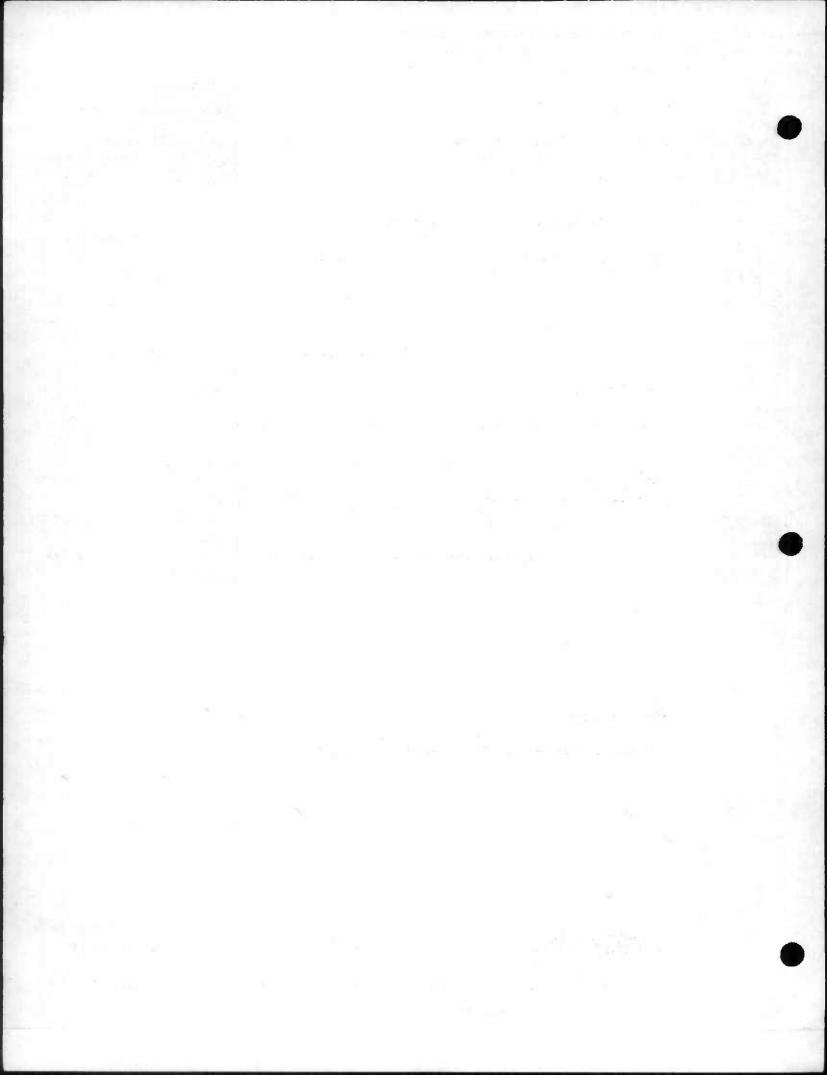
MD 32. Registrar's Signeture

leted ceuse of deeth (Item 23a) (Type, Print)

9800 FALLS RO #104 , POTOME

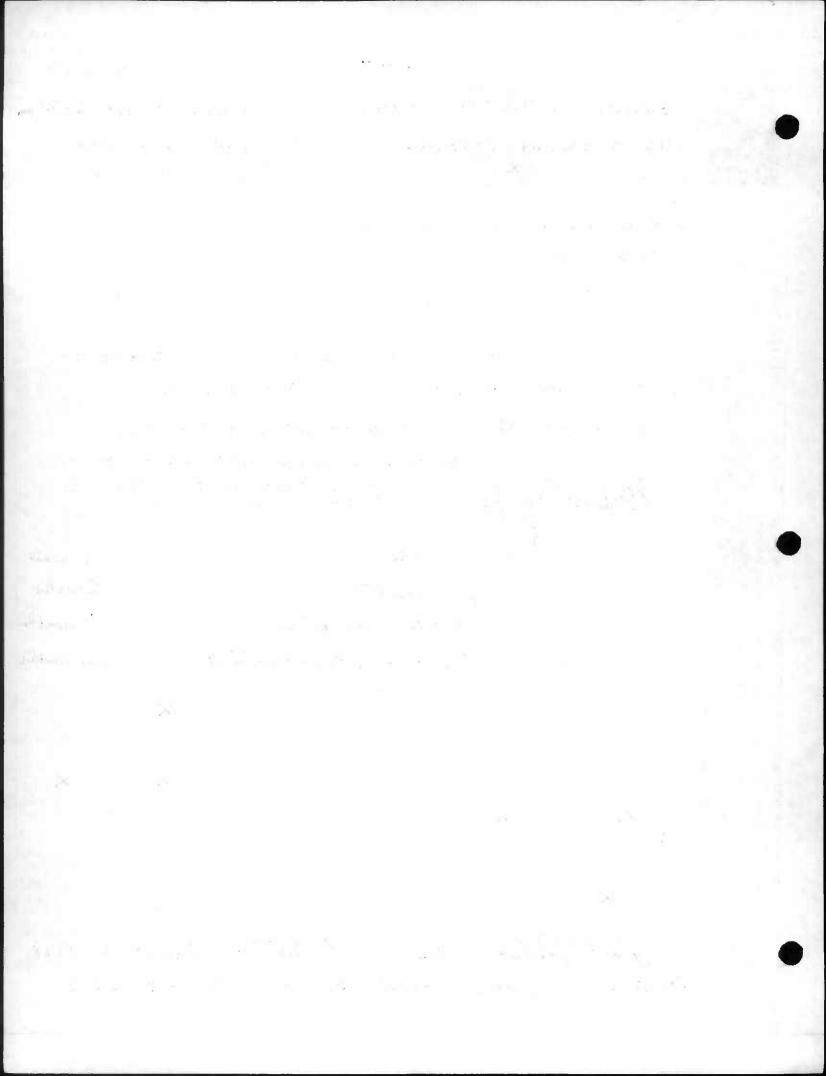
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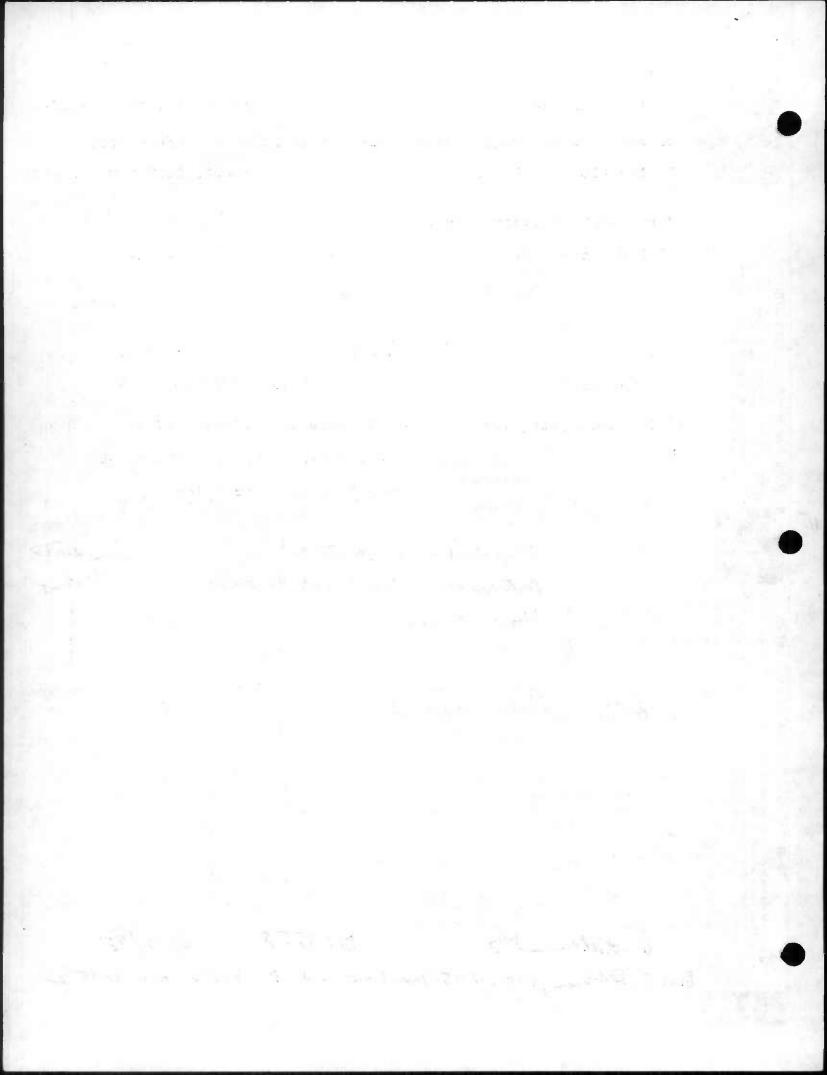
# Ammended Harford County Health Dept. line # 4C & 6 8/20/98 kdg Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ıysiclar	n	1. Decedent's Name (First, Middle	RAN:	som	Qu	AV				2. Dete of De Month	Dey	Yeer	3. Time of De	
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· ·	-	GOOD SAMAR	ITAM	H08 P1	TAL			BAL			-BAL	TIMO	100	
neral otor		5. Sociel Security Number 116-42-5776	6. Sex	7. Age (In yrs	: lest birthdey) Yrs.	If Unde Months	Deys	If Under 24 Hours	Hrs. Min.	8. Date of Bir (Month, De Mar. 2	th y, Year) 6,1950		ece (Stete or F	-oreign
_	-	Usuel Residence of Decedent  10a. State 10b. County		10c, C	ity, Town or Lo	cation						10	d. Inside City	Itmits
Sedat	101	Maryland Harfo	ord		Churchy								1 ☐ Yes 2	
a notifie		10e. Street end Number	JLU		UIGI CITV		p Code				10g. Citizen of	Whet Count	try?	
NARL D	la	1009 Calvary	Road				21028				US.	A		
E .	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie  3 Widowed 4 Divorced	Armed I	ecedent Ever in t Forces? s 2 No Sive Dates:1976-		Was Dece f Yes, spe l□ Yes		ispenic Origir n, Mexican, I Specify:	n? (Spec Puerto R	cify Yes or No Rican, etc.)		ce - America ck, White, e y: Whi	etc.	
		15. Decedent	s Education			lent's Usi	uei Occupa	ation Juring most o	£		16b. Kind of B	usiness/Ind	ustry	
a Med	Completed	(Specify only highes: Etementary/Secondery (0-12)		(1-4or 5+)	Inte. L	JO NOT	ise retired	)		9				
, C	5	17. Fether's Neme (First, Middle, L	act)	4	Mech	anic	al Er	nginee		(Eirot Middle	U.S. Meiden Sumen		nment	
To Be	0 0		ward	Quay,	sr.			Loli		Ethel		110)		
aumatic event, I	-	19e. Informent's Name/Relationsh		Zuuj/ .		g Addres	s (Street		_		er, City or Town,	Stete, Zip	Code)	3-1
or other traumatic event,		Barbara Lynn Q	iav - W	ife	1009	Cal	varv	Road.	Chu	rchvil	le, MD	21028		
or oth		20e. Method of Disposition  1 Burlet 2 Cremetion		206.	Plece of Dispo cemetery, cren	sition (Ne netory or	me of do	e)		Dete	20c. Location	City or Tov	vn, Stete	
hind		4 Donetion 5 □Other (Sp	ecify)		. Zion						Bel Ai			
any injury or other trau		21. Signature of Funeral Service L	Emys,	4-		1317	Coke	esbury	Roa	d, Abi	uneral i	Home, MD 21	P.A. 009	
		23a. Pert1. Enter the diseese, or a shock, or heart feilure. List of	complications the	caused the dea eech line.	th. Do not ente	er the mo	de of dyin	g, such es ca	ardiac or	respiratory e	rrest,		Approximete Intervel Betwee Onset end Dec	en
cian ical		Immediate Cause (Finel		0	- 11							1		
ner		disease or condition resulting in death)	е	Sec.	or es e conseq	uonno of		-				1	1 week 2 week 4 mm	els
a è	5				1000								2 week	60
Fyaminer		Sequentially list conditions,	Ь		or es e conseq			1.0						^
<u></u>		Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury	C	Chr	romic t	ena	I f	leiler	u				4 mm	All,
as the buriel-transit		thet initieted events resulting in deeth) Lest		Due to (	or es e conseq	uence of)	: 0			f.		İ	,	.0
hed for use a			d	Neg	eve	7	sa	m lor	na	lohi		-	ew mm	Nu
detached for use a	31010	Pert II. Other eignificant condition	ne contributing to	death but not re	sulting in the ur	nderfying	cause give	en in Pert I.		23b. Dld	tobecco uee co	ntribute to	the cause of c	deeth?
Phy										10	Yes 20 No	3 Prob	ably 4□Un	ıknowr
3 2										Can Man	E. Carle	24h Wo	re eutopsy find	dinac
should	ובוב									perfo	en eutopsy rmed?	eve	ilebte prior to apletion of caus	_
page 2 should	2									10	Yes 2 No		leeth?	
Be C.		25. Wes case referred to medical						26. Place o	f Death	(Check only o		- '-	Yes 2 No	,
\$ C	0	examiner? 1 ☐ Yes 2X No	Hospitat:	Inpatient 2	ER/Outpetien	t 3□ D	OA Othe	or.			dence 6 □Oth	ner (Specify	)	
unera		27. Manner of Deeth  1 Neturel 5 □ Pending		e of Injury onth, Dey Yeer)	28b. Time of Injury		28c. Injury Work			8d. Describe	now Injury occur	red		
led in by the funera	180	2 Accident Investige 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Plea	ce of Injury - At h ding, etc. (Speci	nome, farm, stre	M eet, facto		Yes 2 □ No		8f. Location (	Street end Numl vn, Stete)	ber or Rural	Route Number	ir.
complately filled in by the funeral		29a. Certifier (Check only one)  (Check only one)	Physicien: To the	basis of exemine	owledge, deeth	occurred	l et the tim	ne, dete end pointion, death	ptace, er	nd due to the	ceuse(s) end mo	enner es ste	eted. the ceuse(s)	
		29b. Signeture and litle of cegifier	end me	enner stated.			c. License				29d. Date signe			
Med	- 1	111	10		4.1		0			)				20
comple		1/2/1/	111.				- 41	/ / -			/	4 1 V	, , , ,	1 V
comple		30. Name and address of person w	tho completed car	se of deeth (Ite	m 23e) (Type I	Print)		123	٠ د	<i>†</i>	Augus, MD	7 18	, ar	18



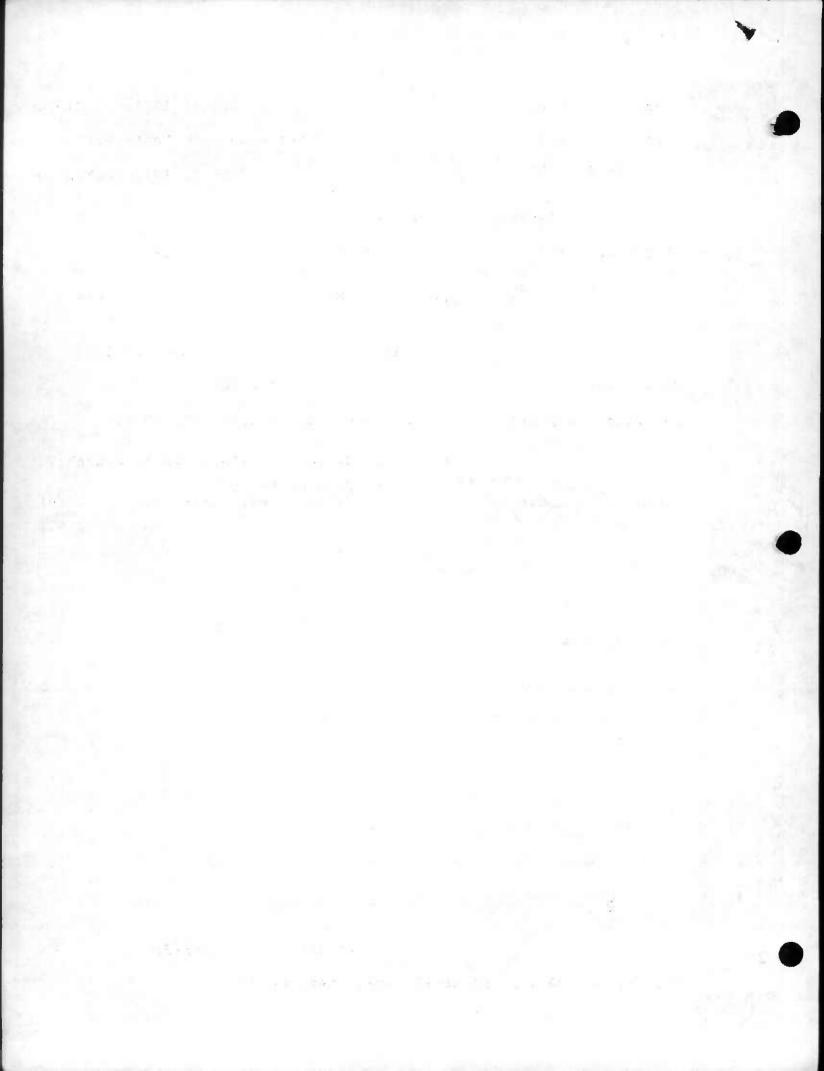
State of Maryland / Department of Health and Mental Hygiene 0 0 5 7 5 5

1. Decedered Name (Port Mother)  1. Desired Classes  1. Desired Cl	Standard Standard					Certif	icate of	Death	F	Reg. No.	1 4	0/00
Example   New Parally Number   Of President   New Parally Number   Of President   New Parally Number   Of President   New Parally Number   Of President   New Parally Number   Of President   New Parally Number   Of President   New Parally Number   Of President	Physicia		1. Decedent's Name (First, Middle, Las	t)					2. Dete of Dee	th	Voor	3. Time of Death
Hebrer Home of Greater Vashington Rockville  Montgomery  087-18-8050									August	14,	1998	1:30pm
## Screen Security Numbers    Security Security Numbers   C. Sec.   M. A. P. A			4e. Fecility Nema (If not institution, give	straet and number)				4b. City, Town, o	r Location of Death	4c. County	of Death	
087—18 - 8050   Mr. Age   98   Vys. Months   Mys. Most   Mr. Age   18, 1899   New York   Ork No. Comp.   100. Comb.   100.												
Was a process of the process of th	Director		087-18-8050	TM OFF	yrs. lest b	M			n. 8. Date of Birtl (Month, Dev Aug. 18	Yeer) 3,1899	9. Birthpl Count New	eca (State or Foraig try) York Ci
Was a process of the process of th	now III		10a. State 10b. County	10c.	. City, To	wn or Location	on				10	Od. Inside City Limits
1.   Author   States   Author   Autho	28a-f sp	rector		gomery Ro	ckv:		Of Zin Code			Ing Citizen of h	Albert Cours	1⊠ Yes 2□No
Specific White    Specific Committee   Com	s 23a or	ral Di	6121 Montrose				2085			U.S.A	Α.	
Secretary Control   Secr	1	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes ② No If Yes, Give	n U,S.				(Specify Yas or No- erto Ricen, etc.)		ck, White, e	etc.
Continued of Part   Continued Services   Continue	natu	etec	15. Decedent's Edu	ucetion (e completed)	166	. Decedent'	s Usuel Occu	pation	orking	16b. Kind of Bu	usiness/Ind	ustry
18. Mother's Name First, Medicine, States		omple	Elementary/Secondary (0-12)		Н			ed)	on king	Own Ho	ome	
23. Part   Enter the dease, or complete forms had caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest.  Approximate the mode of dying, such as cardiac or respiretory arrest.  Approximate the mode of dying, such as cardiac or respiretory arrest.  Approximate the mode of dying, such as cardiac or respiretory arrest.  Immuful dease as consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying and the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying and the mode of dying, such as cardiac or respiretory arrest.  Immuful dease or consequence of the mode of dying arrest.  Immuful dease or consequence of the mode of the cardiac or respiretory arrest.  Immuful dease or consequence of the mode of the cardiac or respiretory arrest.  Immuful dease or consequence of the dease of the cardiac or respiretory arrest.  Immuful dease or consequence of the dease of the cardiac or respiretory arrest.  Immuful dease or consequence of the cardiac or respiretory arrest.  Immuful dease or consequence of the cardiac or respiretory arrest.  Immuful dease or consequence of the cardiac or respiretory arrest.  Immuful dease or consequence of the cardiac or respiretory arre	othe othe	e C	17. Father's Name (First, Middle, Last)					18. Mother's N	ama (First, Middla,	Maldan Sumam	na)	
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State  Sequentially list conditions, if each paper of the	/Medical xaminer				i.	not enter th	e moda of dy	Ing, such es cardi	ac or respiretory arr	est,	7	22201 Approximate Intervel Batween Onset end Death
Due to (or as a consequence of):    Part II. Other significant conditions or injury or resulting in death) Lest    Part III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.   Part III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.   Part III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.   Part III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.   Part III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.   1   Yes 2   No 3   Probably 4   Unix 2   No 24a. Was en europsy performed?		ner		Antonos	ele	rote	5 he	ant de	recie			Jean
25. Wes case referred to medical examiner?    1	nding physician and use as the bunal-trans	Medical	Sequentially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events	Hypert	o (or as a	consequand	ce of):					
24a. Was en eutopsy performed?  24a. Was en eutopsy performed?  24a. Was en eutopsy performed?  24b. Were eutopsy find evailable prior to completion of ceuse of death.  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Wes case referred to medical evaminer?  25c. Place of Deeth. (Check only one)  25c. Wes case referred to medical evaminer?  25c. Place of Deeth. (Check only one)  25c. Place of Deeth. (Check only one)  26c. Place of Deeth. (Check only one)  26c. Injury of the standard of the countries of t	d for	Cla	Pert II. Other significant conditions con	atributing to dooth but not	roculting l	n the under	uine enues el	ues le Dest l	non Dida	h	1	***************************************
25. Wes cese referred to medicel examiner?    1	ed by the deteche		Diabetes me	elitus 7	7pe	II the under	ying ceuse gi	ven in Perti.				
25. Wes cese referred to medical examiner?  1   Yes   No	2 should be	bleted b		/							eva	lable prior to
25. Wes case referred to medical examiner?    1									1 □ Ye	s 2000	1 🗆	Yas 2□ No
State   Stat	ctor.	9	25. Wes cese referred to medicel					26. Piece of De	eth (Check only on	e)		
Nature  2   Accident 3   Sulcida 4   Homicide   See. Plece of Injury - At home, farm, straat, fectory, office   28f. Location (Straet end Number or Rurel Routa Number, City or Town, Stete)   29a. Certifier (Check only one)   29m   Medical Examineer: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end manner stated.   29b. Signature end title of certifier   29c. License number   29d. Date signed (Month, Dey, Year)   30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)   31. Date filed (Month, Day, Year)   32. Registrer's Signature   31. Date filed (Month, Day, Year)   32. Registrer's Signature   32. Registrer's Signature   33. Date filed (Month, Day, Year)   34. Registrer's Signature   34. Registrer's Signature   35. Registrer's Signature   36. Registrer's Signature   3	1 E	-  -	1 ☐ Yes 2 No	1 L Inpatient 2	□ ER/O	utpetient 3	LI DOA	4 Nursing	Home 5 ☐ Reside	nce 6 Othe	er (Specify)	)
29a. Certifier (Check only one) 29medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner es steted.  29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)  30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)  BLA I Jelling Month, Day, Year) 32. Registrer's Signature	r: After he funer	ation	Naturel 5 Pending Investigation	28e. Date of Injury (Month, Day Year		Injury			28d. Describe ho	w injury occurr	ed	
State  St	rat Direct	)	4 Homicide determined	building, etc. (Spe	ecify)				City or Towr	, Stete)		
State  D  State  State  State  D  State  Sta	n 24 hou	anica:	(Check only 2 Medical Examin	ier: On the basis of exam	nowledge Ination en	e, deeth occi id/or investig	urred at the ti gation, in my o	me, dete end plea opinion, deeth occ	e, end due to the ce urred et the time, de	euse(s) end ma ete end piece, e	nner es ste and due to t	ited. the ceuse(s)
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State 31. Date filed (Month, Day, Year) 32. Registrer's Signature			> Bristlell	_ms			D	23958	8	8/14	198	?
State 31. Date filed (Month, Day, Year) 32. Registrer's Signature			80. Name and address of person who co	mpleted ceuse of death (II	tem 23e)	(Type, Print)	rose	ld. R	ozkují	e, ms	20	852
	State Registrar		31. Date filed (Month, Day, Year)			4	10- "	,,				



State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Dacedant's Nama (First, Middla, Las	1)			Death	2. Data of De	Reg. No.	3.1	Tima of Daath
	n	Samuel H. Ro					Month Augu	Day	Year	3:05pm
Medica/ Examine		4a. Facility Nama (If not institution, give				4b. City, Town, or				3.03 hm
Examme	ľ	6301 Lenox Roa				Bethe			tgomer	47
uneral		5. Social Sacurity Number 6. Sa	x 7. Aga (/	n yrs. lest birthday	If Under 1 Yaar	If Undar 24 Hrs	8. Data of Bi			
irector		578-16-7654  Usual Rasidance of Dacedant		3 Yrs.	Months Days	Hours Min.	July	13,191	Country) 5 Wash:	State or Foreign
A ==	-	10a. Stata 10b. County	10	Dc. City, Town or L	ocation					slda City Limits
Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner mant be notified at once.	ō	Maryland Mont	gomery	Bethe	sda					Yas 2□No
nott	9	10e. Street end Numbar			10f. Zip Coda			10g. Citizen of	What Country?	
N N	runeral Director	6301 Lenox Roa	d		20817			U.S.		
E.	ner	11. Marital Status	12. Was Decadent Eve	or In U,S. 13.	Was Decedant of H If Yas, specify Cube	lispanic Origin? (S	pecify Yas or No	)- 14. Rac	ca - American Inc	dian,
Examine	2	1 ☐ Never Marriad 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forcas? 12⊈ Yes 2 □ No If Yas, Giva Year or Datas: W		1 ☐ Yas 2 ☐ No	an, Maxican, Puari Specify:	to Rican, etc.)	Specif	ck, Whita, atc. y: White	е
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Meso	ble	(Specify only highest grad	la complatad) Collega (1-4or 5+)	(Give	dent's Usual Occup a kind of work done DO NOT usa retired	auning most of wor d)	rking			
1	Completed		4	Reta	il Jewe	ler		Self-	Employe	e d
even	9	17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nar			ne)	
-	2	Henry Root					r Wolf			
тапш		19e. Informant's Name/Relationship (7)	THE STATE OF THE S		ing Addrass (Streat					)
Leg Leg	-	Beatrice Root/			Lenox	Rd.Beth			817	
5	1	20e. Mathod of Disposition 1 □ Burial 2 □ Crametion 3 □ F	Ramoval from Stata		matory or othar place		Data		City or Town, Si	
	-	4 Donation 5 Other (Specify)			vid Mem		8/13/9	8 Fall:	s Churc	ch, VA
once		21. Signeture of Funaral Sarvice Licens	00 mosty		2. Nama and Addre Ves-Pea:	ss of Facility rson Fu	neral	Home		
		Wor G. New	ester fruit	2	847 W11:	son Blv	d. Arl	ington	, VA 2	22201
ian		<ol> <li>Part1. Enter the disease, or complete shock, or heart failure. List only or</li> </ol>	ications that caused the na cause on each line.	daath. Do not an	tar tha mode of dylr	ng, such as cardiad	or respiretory e	rrast,	Intan	oximata vel Batwean it end Daeth
lical		Immadiata Causa (Final disaasa or condition	Pneu	monia					2 v	veeks
ner	P	rasulting in deeth)		a to (or as a conse	quanca of):				V	CLES
					inson's	Diseas	e		5 3	ears
8	100	Sequentially list conditions,	Due	to (or as a conse	quance of):					
u d	3   5	Sequantially list conditions, if eny, laading to Immadiata causa. Entar Underlying Cause (Disaasa or Injury			4-23-33		200			
Evaminar	1	that Initiated avants rasulting in daath) Last	Due	to (or as e consec	quance of):					
D =			1.							
1 -	3									
, and										
veician	F	Part II. Other significent conditione cor	stributing to death but no	ot rasulting in the u	inderlying causa giv	an in Pert I.	23b. Did	tobacco uae co	ntribute to the c	aues of death?
V Physician/L		Part II. Other significent conditions con							ntribute to the c	
hy Phyei	3						10	Yes 2□ No	3 Probably	4 Unknown
eted by Dhyel	3						1 □		3 Probably  24b. Were aut available completic	4 Unknown topsy findings prior to on of causa
eted by Physi	3						1 □ 24a. Was	Yes 2□ No an autopsy rmed?	24b. Were autavailabla completic of daath?	4 Unknown topsy findings prior to on of causa
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iffication: To Be Completed by Physi	2	Arteriosclerot	Lc Cardio	vascula  2 ER/Outpatlet  ar) 28b. Tima o Injury  At homa, farm, str	r Diseas	26. Placa of Dea ar: 4 \( \text{ Nursing H} \)	24a. Was parto	Yes 2□ No an autopsy rmed?  Yes 2□ No ona) denca 6□Oth how injury occur.	3 Probably  24b. Were autavailabla completit of daath?  1 Yas	4 ☐ Unknown topsy findings prior to pn of causa 2 ☐ No
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Certification: To Be Completed by Physic	2	Arteriosclerot  25. Was casa rafarrad to medical axaminer?  1   Yas   2   No  27. Manner of Death  12   Accidant  3   Suicida  4   Homicida  29a. Certifiar (Check only one)  2   Medical Examin	Ic Cardio	2 ER/Outpaties ar) 28b. Tima o Injury At homa, farm, stripacify)	nt 3 DOA Oth f 28c. Injun Wor M 1 raat, factory, office	26. Placa of Dea ar: 4 Nursing H yet k? Yas 2 No	24a. Was parto	Yes 2 No an autopsy primed?  Yes 2 No ona) denca 6 Oth how injury occur.  Streat and Numb. wn, Stata)  causa(s) and medata end place,	3 Probably  24b. Were autavailable completic of daath? 1 Yas  ar (Specify)  red  per or Rural Route ennar as stated, and due to the ce	4 ☐ Unknown  topsy findings prior to pn of causa  2 ☐ No  a Number,  euse(s)
Illied in by the funeral director, page 2 should be deteched for the form of t	2	Arteriosclerot  25. Was casa rafarrad to medical axaminer?  1   Yas   2   No  27. Manner of Death  12   Accident  3   Suicida  4   Homicida  29a. Certifiar  (Check only  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  2   Medical Examiner  3   Medical Examiner  4   Me	Ic Cardio    Iconomic	2 ER/Outpaties ar) 28b. Tima o Injury At homa, farm, stripacify)	nt 3 DOA Oth f 28c. Injun Worl M 1 raat, factory, office	26. Placa of Dea ar: 4 Nursing H yet k? Yas 2 No	24a. Was parto	Yes 2 No an autopsy primed?  Yes 2 No ona) denca 6 Oth how injury occur.  Straat and Numb vn, Stata) causa(s) and me data end place, 29d. Date signe	3 Probably  24b. Were aut available completic of daath?  1 Yas  ar (Specify)  red  ennar as statad. and dua to the cell of the	4 ☐ Unknown  topsy findings prior to pn of causa  2 ☐ No  a Number,  euse(s)
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he Funerel Director: After this certificate has been signer plately filled in by the funerel director, page 2 should be deficial Certification: To Be Commisted by	2 2 3	Arteriosclerot  25. Was casa referred to medical axaminer?  1   Yas 2   No  27. Manner of Death  12   Accidant  3   Suicida  4   Homicida  29a. Certifiar  (Check only one)  29b. Signetura and title of certifiar  29b. Signetura and title of certifiar  200. Name end eddrass of person who co	Ic Cardio    Inpatiant   28a. Data of Injury (Month, Day Ye   28a. Place of Injury building, atc. (S   18a. Cardinary of the basis of axa and magnar stated.	vascula  2 ER/Outpatier  ar) 28b. Tima o Injury  At homa, farm, stripacify)  y knowledge, daatt umination end/or in  (/tam 23a) (Type,	T Diseas  Other  at 3 DOA Other  f 28c. Injuny  M 10  reat, factory, office  reating at the time vastigation, in my operation of the control	26. Place of Dealer: 4 Nursing H	24a. Was parto	Yes 2 No an autopsy primed?  Yes 2 No ona) denca 6 Oth how injury occur.  Straat and Numb vn, Stata) causa(s) and me data end place, 29d. Date signe	3 Probably  24b. Were aut available completic of daath?  1 Yas  ar (Specify)  red  ennar as statad. and dua to the cetted (Month, Day, Y	4 ☐ Unknown  topsy findings prior to pn of causa  2 ☐ No  a Number,  euse(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month Dey BEN RATCLIFE WARREN 22:25 N1 199 AU 9 H /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HAVREREGR HOSP MEMONAL HARFORD HANFOND If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. Sept. 28, 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Ř<sup>œr)</sup>1947 M 2□ F Georgia 427-98-3793 Yrs. Director 50 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Maryland Harford Aberdeen 10f. Zip Code 10e, Street end Number 10g. Citizen of Whet Country? filed within 72 hours after death with 143 Farm Road 21001 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Stetus 1 Never Married Married 21215-0020 1 Yes 2€ No Specify: py Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry i Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Instructor U.S Government Baltimore, Maryland 17. Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) . Pages 1 end 2 should be fil ment of Haalth end Mental H tent: If item 27 is marked off jury or other traumatic even Be Sandy Ratcliff Lo Louise Rinkens 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Lillie Ratcliff (Spouse) 143 Farm Road, Aberdeen, Maryland 21001 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Depertment of Important: If any Injury or New Bethel Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3/17/98 Hattiesburg, Miss. 21. Signature of Fuperal Service License 22. Name and Address of Fecility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23e. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin eath. Do not enter the mode of dying, such es cerdiac or respiretory errest, Approximete Intervel Betwe Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting In deeth) /Medical ASCUD **Examiner** Due to (or es e consequence of): Examiner The law requires that the death certificate be axecuted the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physiclan/Medicai Due to (or es e consequence of): for usa es signed by the at d be detached for P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? pega 2 should Completed 24e. Wes en eutopsy performed' certificata has 1 ☐ Yes 2 No 1 Yes 2 No of Vital or Attending Physician: director, Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this the funeral 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 5 Pending Investigation 1 Neturel Injury s after daath. 2 Accident NA 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier Medical completaly (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 111998 DMG OUME 30. Name a nd address of person who completed ceuse of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) AUG 1 7 1998

MABHU M.D

32. Registrer's Signeture

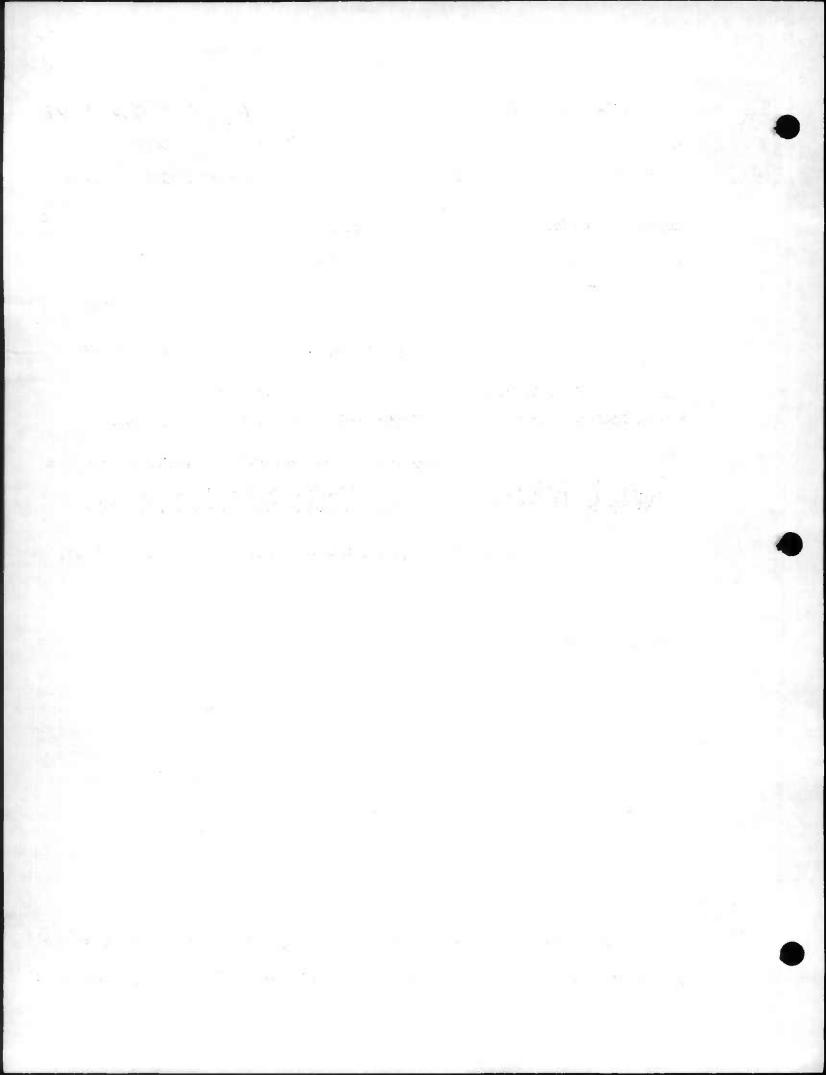
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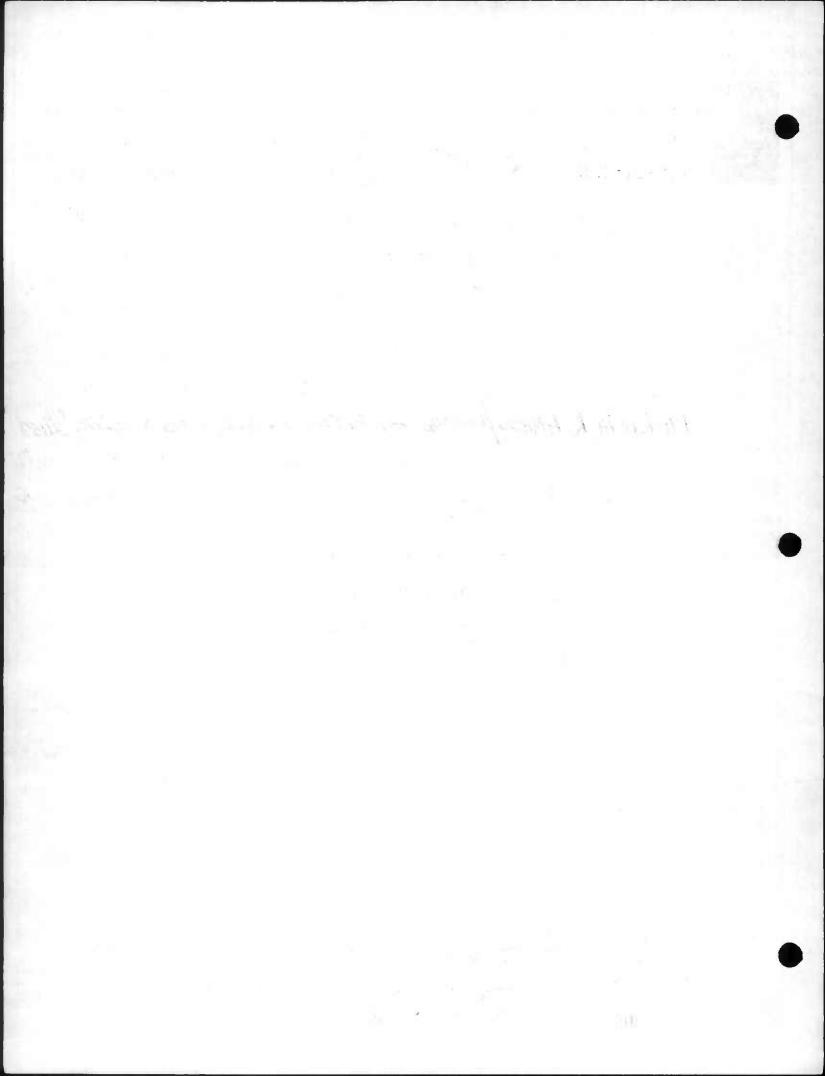
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma		Certificate of			eg. No.	26768
Р	hysici	an	1. Decedent's Neme (First, Middle, L					2. Dete of Deet	h Day	3. Time of Death
	/Medic			DBINSON				AUSWI	+ 51	998 1626
<i>)</i> E	xamir	er	4e. Facility Name (If not institution, g	va street end number)			4b. City, Town, or L		4c. County	
		_	Union Hospital  5. Sociel Security Number 6.	Sex 7. Aq	//n ure loot him	hday) If Under 1 Yea	Elkton		Ceci	
1000	neral ector		212-46-5126	1⊠M 2□F	(In yrs. lest birt	Months Deys		8. Date of Birth (Month, Day,		Birthplace (Stete or Foreign Country)
	COLO		Usual Residenca of Dacedent					October	12,1946	Virginia
rylenc	M M		10a. Stete 10b. County		10c. City, Town	or Location				10d. Inside City Limits
e Ma		Director	Maryland Harfo	ord		Abingdor	1			1 ☐ Yes 2 X No
章 章	0 2	Dire	10e. Street end Number			10f. Zip Code		10	Dg. Citizen of W	het Country?
ath w			7 Porter Drive			210			USA	
Ind 21215-0020  be filed within 72 hours after death with the Maryland lei Hygiene.	of items 23a of 284-1 show minar must be notified at	Funeral	11. Marital Status  1 ☐ Never Merried 2 ☒ Married	12. Wes Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N		13. Was Decedent of If Yes, specify Cul	Hispenic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indien, c, White, etc.
020 urs a	No.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yas 2X No	Specify:		Specify:	White
21215-0020 d within 72 hours af giene.	tion 27 is marked other than "natural", other traumatic evant, the Wedgal Exa		15. Decedent's E	ducation	16e.	Decedent's Usuel Occu	pation		16b. Kind of Bus	
21 Bir	Med	Completed	(Specify only highast gi Elementary/Secondary (0-12)	ede completed) College (1-4or 5	+}	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin		ang		
d 212 filed withi Hygiene.	t, the	Con	8			Owner/Opera				ruction
pur partition	marked other than imatic evant, the M	Be	17. Fether's Neme (First, Middle, Las	1)			18. Mother's Nam	e (First, Middle, A	faiden Sumama	1)
aryla should b	natic	4	Richard Theodor					Matilda		
2 2 2 2	traun		19a. Informent's Name/Relationship Roxanne Robinson			Mailing Address (Stree Porter Driv				
e, N 1 and Health	thar		20a. Method of Disposition	WILL		Disposition (Neme of	re, Aoringa			21009 Dity or Town, State
Baltimore,	= ŏ		1 ☐ Burial 2 ☐ Cremation 3		cemeter	y, cremetory or other pla	1			
Baltimo	any Injury		4 ☐ Donation 5 ☐ Other (Special Structure of Funeral Service Lice	-	Highvie	w Memorial 22. Name end Addr		8-8-98	Fallsto	on, Maryland
a a	any Ir		A DIAMO	$\Delta \Omega \Lambda_{\star}$	0. •	Howard K	McComas	III Fune	eral Hor	me, P.A.
			23e. Part1. Enter the sease, or conshock, or heart lure. List only	plications that ceused	the deeth. Do n	1317 Coke ot enter the mode of dy	esbury Roa ring, such as cardiac	ad, Abino or respiretory erre	gdon, M	21009 Approximate
Phys	ician		snock, or naar, Lure. List only	one cause on eech lin	е.					Intervel Between Onset end Deeth
	dical		Immediate Ceuse (Finel disaasa or condition	AC	UTE A	MYOCARI	PIAL IN	FARC	TION	1 1744
Exan	niner		resulting in deeth)	θ	Due to (or es e c	167011				
D <sub>0</sub>	sit.	line		h						
aecute	I-tran	Examiner	Sequentially list conditions,	D	Due to (or as e c	onsequence of):				
68760, ficate be ex	bune	a E	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	c						
68760, ificate be executed	es the bunel-transit	edical	rasulting in deeth) Last	ı	Dua to (or as e co	onsequence of):				
Centil	use e			d						
Box	d for	icia	Pert II. Other significant conditions	andribusing to double by	A mak as sublam to	the control for an area	been to Board	AOL DIA		
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Division To the Hospital or Attended within 24 hours effect death	completely filled in by the funeral	edical	(Check only one)	miner: On the basis of end menner sta	exeminetion end	death occurred et the t Vor Investigation, in my	opinion, deeth occur	end due to the ce red et the time, da	use(s) end mer ite end place, e	nner es steted. nd due to the ceuse(s)
To the within	dwoo	M	29b. Signature end title of certifier		1 1	, 29c. Licen	nse number	29	d. Date signed	(Month, Dey, Year)
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			30. Name end eddress of person who	completed cause of de	oth /Hom 23a) (	Tuno Brint)				
			ANDREW NOW	UAKOWSI	<1 n	12 /145	N, MA	IN ST.	BELA	4R, MD2/014
	Sta		31. Dete filed (Month, Dey, Yeer)	32. Registre	r's Signetur	dall				
R	egistr	ar	AUG 1 193	10						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 9 8 P MARDELE KICHTER /Medical Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 7. Age (In ) s. last birthday) If Under 1 Year Months Days lest minister ARROL ARROLL LithERAN if Under 24 Hrs. 5. Social Security Number Dete of Birth (Month, Dev. 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 220-36-9646 1 M 2 F Hours Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside effy Limits 28a-f show traumatic event, the Medical Examiner naunt be notified at 1 Yes 2 No Director MD CARROLL WestminsTER 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 6 Apr 117 Herns 23a USA 205 2115 8 MARK MAY Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - Americen Indian, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Heelth and Mental Hygiene. Important: If item 27 is merked other than "natural" or haven july or other trainment. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 200 No Specify: WhITE by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind ot Business/Industry Elementery/Secondary (0-12) Gollege (1-4or 5+) TEACHER SC HOO 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Dillians DAISY HOMPSON 19e. tnforment's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) DAUCHTED / BSTMINSTER, 21157 20c. Location - City or Town, Stete 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 1 Burial 2 ☐ Cremetion 3 Removel trom State Merado 4 ☐ Donetion 5 ☐ Other (Specify) 12 21. Signature of Funerel Service 22. Neme end Address of Facility Westpurstag PRITO Fineral 23a. Pert1. Enter the of case, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final COBBURAL HOMATOMA diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): HYPERTENS ION The law requires that the death certificete be executed Exami -tren Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest end Due to (or es e consequence of): ettending physician e for use es the buriel-P.O. Box 68760. HUPERCHOLOGERALOMIA Physician/Medicai the Due to (or es e consequence of): 98 use use ed by the e Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed I should be det Records, ò 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed page 2 s certificete 1 Tyes 2 1 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

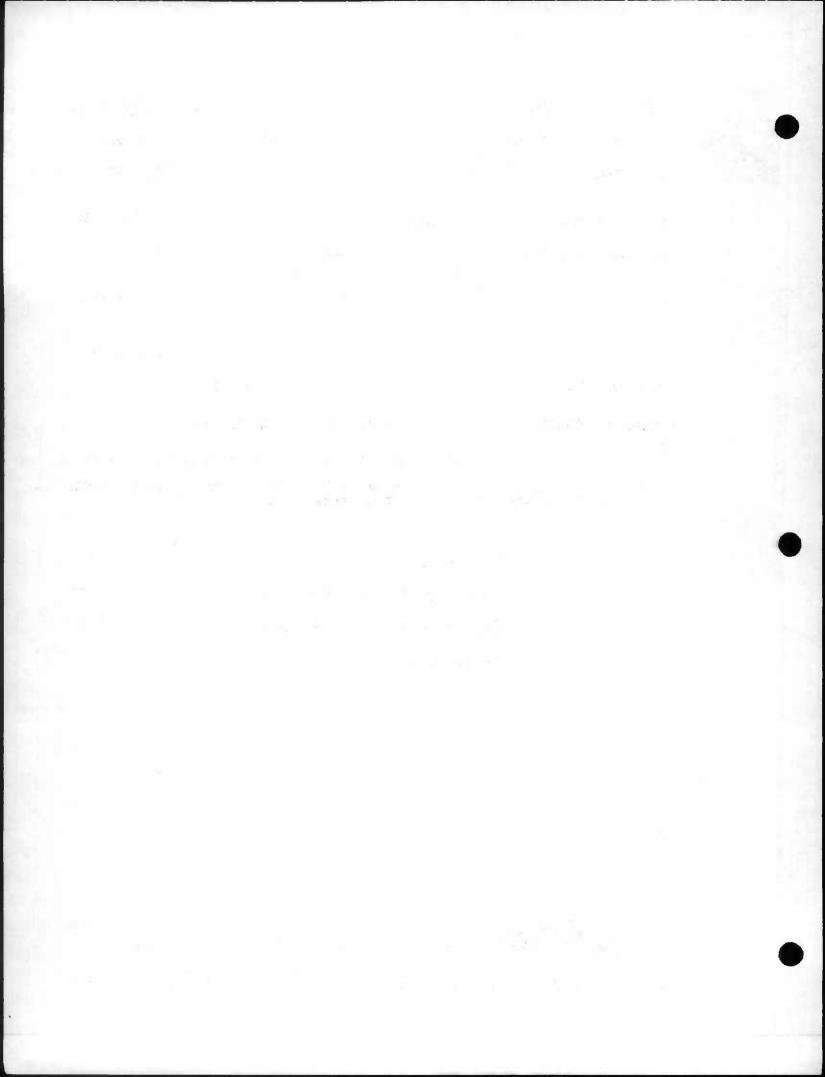
To the Funeral Director: Affer this certifice completely filled in by the funeral director, to Be 25. Was case reterred to medicel 26. Piece of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time ot 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 4 Homicide Medicai 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wy D48189 11 1998 completed cause of death (Item 23e) (Type, Print) Aug 30. Name end address of preson who MARY CAND 21158 32. Registrer's Signature SI MARIL WOSTANINSTER WAG 31. Dete filed (Month, Day, Year) State Registrar **AUG** 1 8 1998



State of Maryland / Department of Health and Mental Hygiene Q

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month BESSIE SYRTLL ROLLYSON AUGUST 19, 1998 /Medical 7:25pm4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner WILLIAM HILL HEALTH CARE EASTON TALBOT 8. Date of Birth (Month, Day, Year) MAY 24, 1904 If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) WEST VIRGINIA **Funeral** Months 1 M 2 XF 94 Yrs Director 233-70-7368 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner ownt be notified at Director XX Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 501 DUTCHMAN'S LANE 21601 USA by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Americen Indian, Black, White, etc. filed within 72 hours after 1 □ Never Merried 2 □ Married 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) TEACHER EDUCATION Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I nt: If item 27 le marked ot CHARLES W. MOORE MARY McLAUGHLIN 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA R. DRYDEN 707 ELWOOD AVENUE, EASTON, MD 21601 If item 27 or other t 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removel from State permit. Page Department of Important: If any Injury or once. 8-25-98 GASSAWAY, WEST VA SUGAR CREEK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Ostrowsk. Joseph M. 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a/consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the 80 USB 5 ed by the a Part il. Other algnificant conditione contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No signed t Records, à 24b. Were eutopsy findings evailable prior to completion of ceuse of death? page 2 should Completed 24a. Was an eutopsy performed? 21 No certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director, Be 25. Was cese referred to medicai 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 3□ DOA this funeral 27. Menner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours 1 Certifying Physictan: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated. 29a, Certifier Medicai completely (Check only one) within 2 the th 29b. Signature end title of the 29c. License number 29d. Date signed (Month, Day, Year) MD 025750 Id/will Are Easton MD 21601 30. Name end address of person who completed cause of death (item 23a) (Type, Print) 160BERT 13. SANCHEZ Ms 501 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State AUG 2 1 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day **Physician** 13, Robert Church Stroud 9:00 AM 1998 August /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Carriage Hill- Bethesda Bethesda Montgomery 5. Social Sacurity Number 6 Sax If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) **Funeral** Months Min. 1₩ 2□ F Days Hours Yrs. Director 123-05-4688 80 January 5, 1918 | California Usual Rasidanca of Dacedan with the Meryland 10a Slata 10b County 10c. City. Town or Location 10d. insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Directo Maryland | Montgomery Chevy\_Chase 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4450 South Park Avenue 20815 United States Funeral death 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours efter 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 X Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: λq 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry n end Mentel Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) 5+ Physiologist N.I.H. traumatic event. 18. Mothar's Nama (First, Middle, Maiden Surnama) 17 Fathar's Nama (First Middle Last) permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If item 27 is marked of James Robert Stroud Henrietta Sophia Tish 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Catherine Aye Stroud/Wife 4450 South Park Avenue, Chevy Chase, Maryland 20815 other 20b. Place of Disposition (Nama of cemetary, cremetory or other place)

Montgomery Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, Stata 20 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Nama and Address of Facility Robert A. Pumphrey Funeral Home/ ature of Europeal Sa Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 sa, or complications that causad tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximeta interval Batween Onsat and Death **Physician** tmmediata Causa (Finat disaasa or condition rasulting in death) /Medical Acute Myocardial Infarction Immediate Examiner Due to (or as a consequanca of): Examiner Coronary Artery Disease 10 Years cartificate be executed physician end the buriel-tran Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Ceuse (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consaquance of): Box 68760 Physician/Medical Dua to (or as a consaquanca of): 98 use 0 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the causa of death? P.0. the signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed peed hes page 2 1 TVas 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital director 25. Was cesa rafarrad to medicel Be 26. Placa of Daath (Check only ona) Othar: 4 ☑ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 1 Yas 2 No 1 Inpatiant 2 ER/Outpatien 3 DOA this funeral 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? After 5 Panding 1 SNetural i or Attendin efter death. Director: Aft 1 Tas 2 🗆 No invasligation 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida Hospital 24 hours e 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the causa(s) and manner es stated.

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29a. Certifiar (Check only one)

31. Data filad (Month, Day, Yaar) 18

29b. Signatura and Miles certifier

James J. Foster, M.D. 5530 Wisconsin Avenue, #925, Chevy Chase, Maryland 20815-4330 32. Pegistrar's Signatura

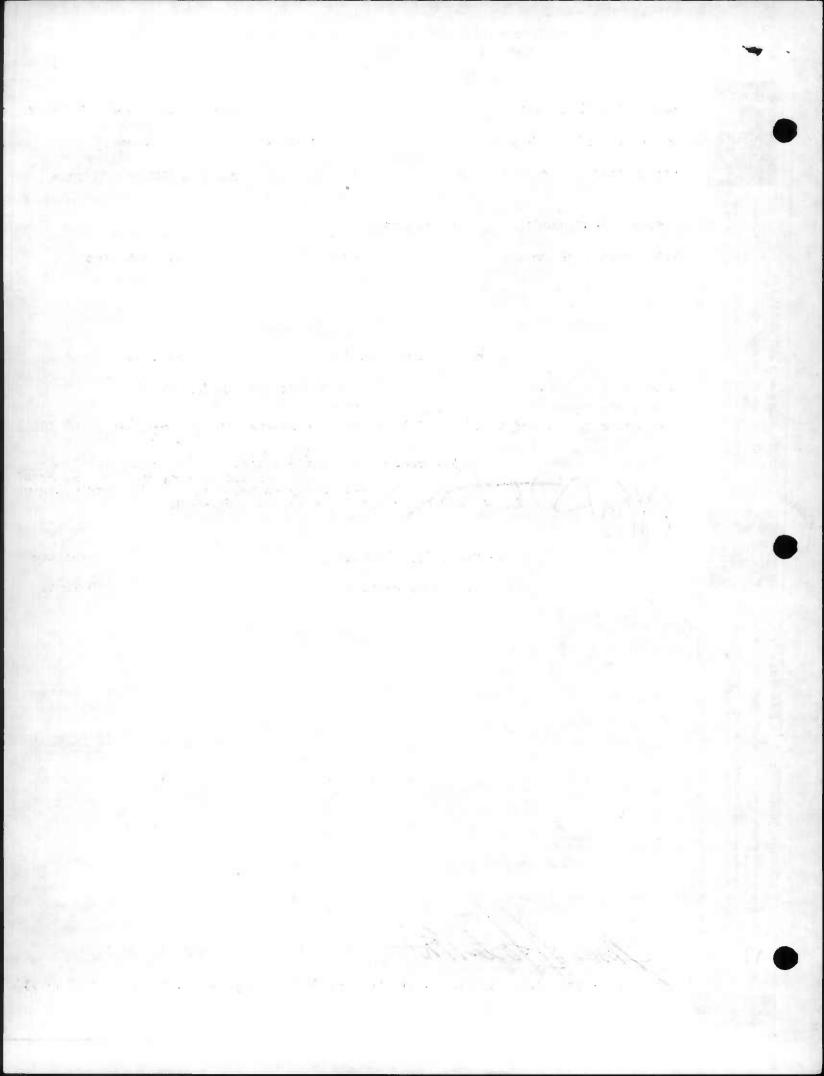
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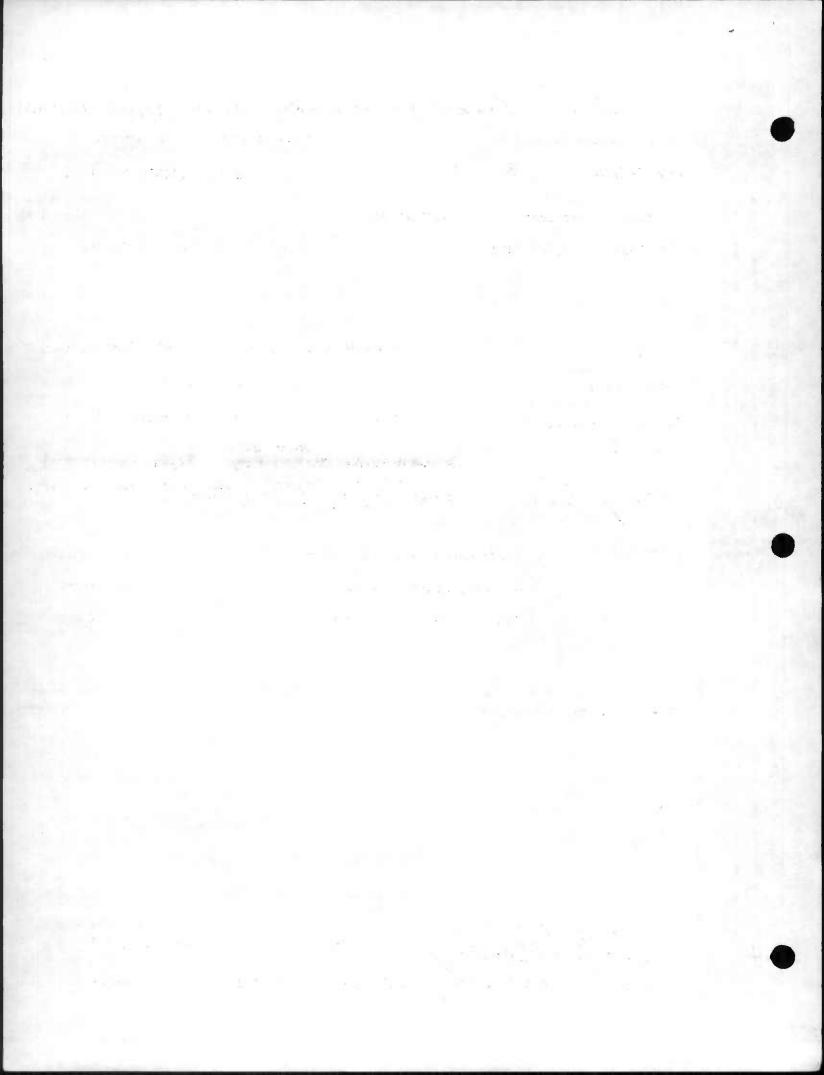
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August 14, 1998



State of Maryland / Department of Health and Mental Hygiene 98 26772

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death Day Month Ethel Tesh Stout August 14, 1998

4b. City, Town, or Location of Death

4c. County of Death 6:00 AM 4a Facility Nama (If not institution, giva street and number) 1600 Brisbane Street Silver Spring Montgomery If Under 24 Hrs. If Under 1 Year Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days Hours Months 1 M 20xF 92 Yrs 579-07-9755 April 15, 1906 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1600 Brisbane Street 20902 **IISA** 14. Race - American Indian, Black, White, atc. 12. Was Decedenf Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Joseph A. Tesh Mary Lewis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 1600 Brisbane Street, Silver Spring, MD Diane Hall (daughter) 20902 20b. Placa of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a Mathod of Disposition Data 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stata Parklawn Memorial Park 4 Donation 5 Other (Specify) 8/17/98 Rockville, MD 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funaral Service Licenses illia Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that daused the death. Do not antar the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediata Causa (Final Acute Renal Failure 3 months disease or condition resulting in death) Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death buf not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Chronic obstructive lung disease 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Alzheimer's disease 1 □ Yas 2 □ No 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 should be filled Department of Health and Mental Hyg Important: If Item 27 is merked other any injury or other traumatic event.

**Physician** 

/Medical

Examiner

Directo

Funeral

à

Completed

Be

2

**Funeral** 

Director

than "natural", or items 23s or 28s-f the Medical Examiner must be notified

hours after

Baltimore, Maryland 21215-0020

Box 68760.

Examiner

physician and s the burial-transit that the death cartificate be executed attending | signed by the a d be detached f been a certificata has paga 2 director, the state of funeral

Physician/Medical 2 Completed Be

To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Certification: To

Medical

1 Natural 2 Accident

3 Suicide

4 Homicide

Records, P.O. Division of Vitai

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) \*Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Cartifier (Check only one) 29b. Signature and title of certified

5 Pending invastigation

6 ☐ Could not be determined

29c. License number D03792

28c. Injury at Work?

1 Yas 2 No

29d. Data signed (Month, Day, Year) 8/14/98

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

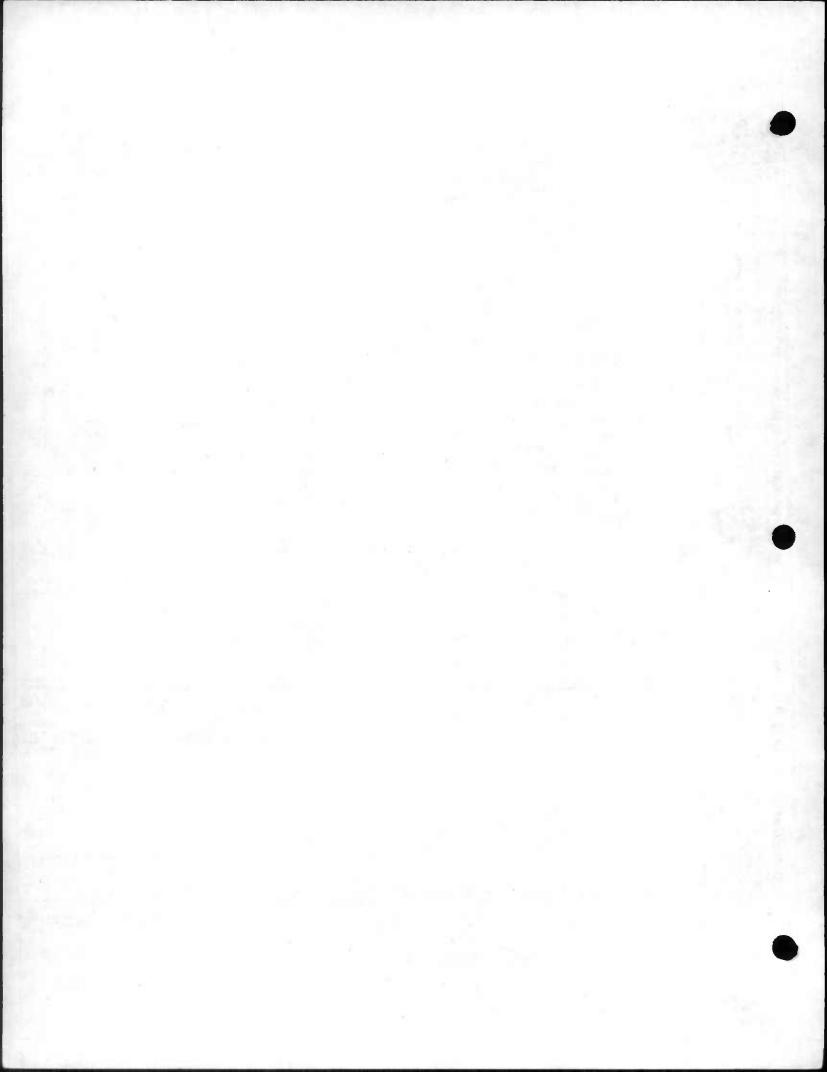
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

10301 Georgia Avenue, Silver Spring, MD Irnest S. Oser, MD.,

28b. Time of

State Registrar 31. Dafa filed (Month, Day, Year) AUG 17 1998

32. Registrar's Signatura

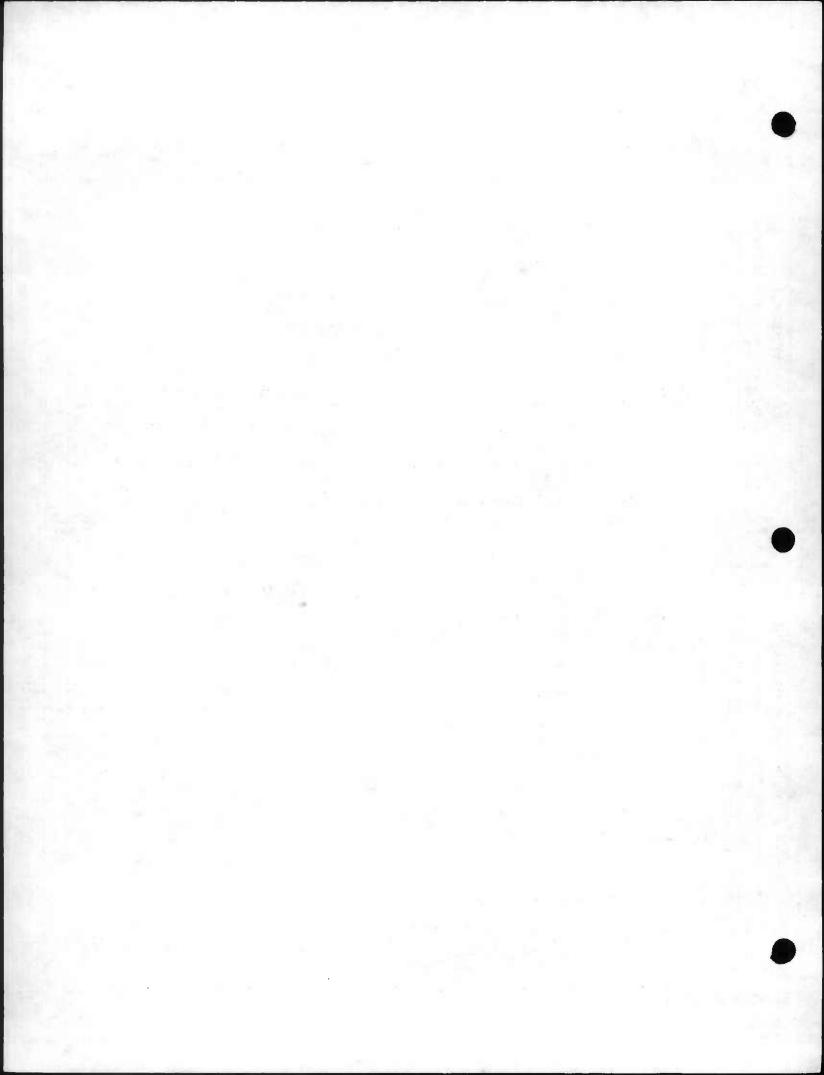


State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death Day Month Year **Physician** CONSTANCE E. SALB AUGUST 16, 1998 10:47 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2XF Director 579-14-4311 80 Nov. 13, 1917Washington, D.C. Usuel Rasidance of Dacedant the Meryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 12509 Connecticut 20906 Funeral Avenue USA 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. hours after 1 ☐ Yas 2 ☑ No If Yes, Give 1 ☐ Never Merried 2 ☑ Married Baltimore. Marviand 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hyglene. Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Teller Banking 17. Father's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middle, Maiden Sumema) permit. Pages 1 end 2 should be file Department of Health and Mentel Hy Important: If frem 27 is marked other any Injury or other traumatic avent once. Be 2 Wells Harrel1 Elizabeth L. Hatton 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) 12509 Connecticut Avenue Bernard F. Salb (Husband) Silver Spring, Maryland 20b. Piace of Disposition (Nama of cematery, cremetory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 5 ☐ Othar (Specify) 8/17/98Silver Spring, Maryland 4 Donation Gate of Heaven Cemetery 21. Signature of Euneral Service Licensee 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc. obser amsle 500 University Blvd., W., Silver Spring, MD 20901 23a. Part1. Entar tha disease, or complications that caused tha shock, or heart feilura. List only ona causa on each line Approximata Intarval Between Onset end Death eath. Do not entar tha moda of dying, such as cardiac or respiratory arrast, **Physician** /Medical tmmediate Ceusa (Final Pinueminia disaasa or condition rasulting in daath) Examiner Due to (or as a consequance of): Examiner Resperator physician and the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last that the death certificate be execu Box 68760 Dua to (or un consequence of): Physician/Medicai 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 Unknown signed I Records, à 24b. Were autopsy findings available prior to complation of cause of death? should Completed 24e. Wes an autopsy pege 2 and No 1 Yas 1 ☐ Yas 2 P No of Vital Attending Physician: director, 25. Was casa refarred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 8 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division Natural 5 Panding 1 Yes 2 No death. invastigation 2 Accident after deat 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) à 4 Homicide filled if n 24 hours a Hospital Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, end dua to the cause(s) end menner as stated.

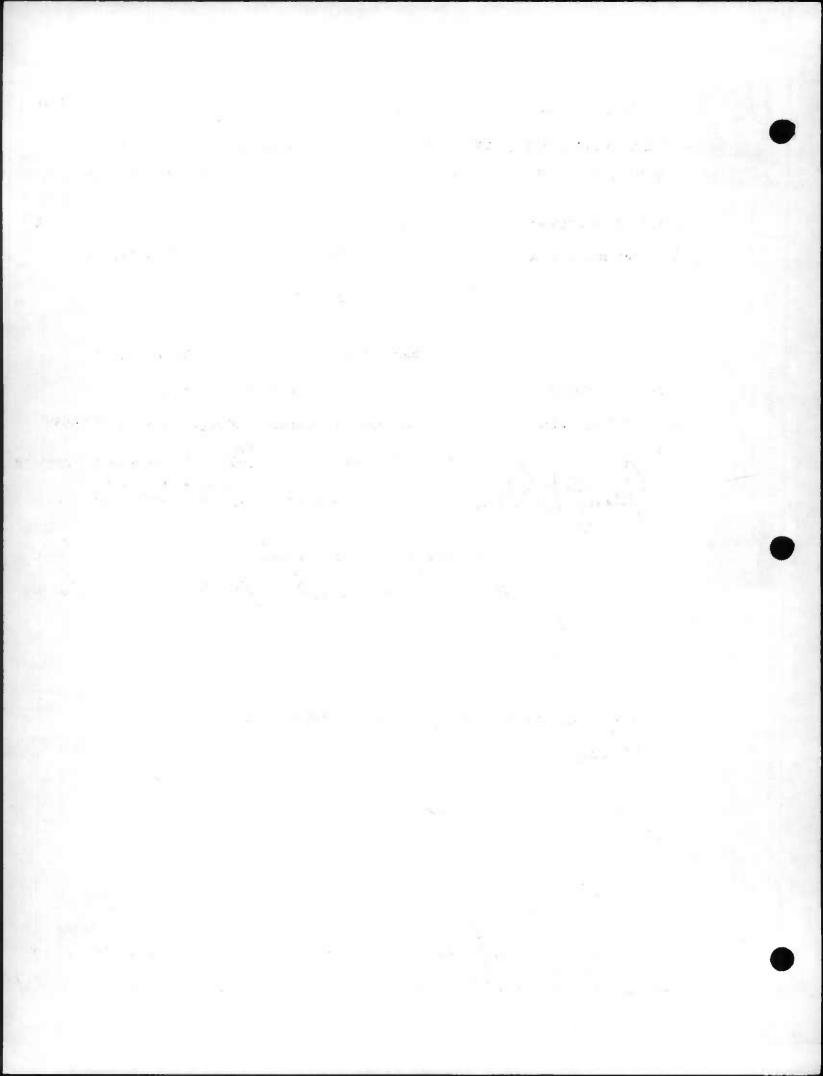
| Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the tima, date and place, end dua to the cause(s) and mannar stated. 29a. Certifian edicai (Check only one) To the Within 2 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signetura and titla of certifian 30. Nama and address of person who completed sausa of daath (ttem 23a) (Type, Print) 4701 Randolph Road #203 Silver Spring, Maryland 20852 Suresh C. Gupta, M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 8 1998 Registrar

DHMH 16 Rev 6/95

Brid



	State of Marylar	Certificate of Dea		26/15										
Physician	Decedent's Name (First, Middle, Last)	C 11	2. Data of Death  Month Day Y	3. Tima of Death										
/Medical	William E.	Selby		98 6 17										
Examiner	4a Facility Name (If not institution, give street and number)	4b. City	, Town, or Location of Death 4c. County of	Death										
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the Maryle 28=1 shon notified at	Maryland Montgomery Wa	shington Grove		1 ☐ Yes 2 ☐ No										
or 28	10e. Street and Number	10f. Zip Code	10g. Citizan of Wh	at Country?										
th wi	407 Chestnut Avenue	20880	United S	tates										
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or he	1 Navar Marriad 2 Married 1 ☐ Yes 2 No			Whita, atc.										
Urs e urs e	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Spec	cify: Specify:	white										
1 21215-0020 led within 72 hours ef bygiene. Per than "natural", or nt. the Medical Exam. Completed by F	15. Decedent's Education	16a. Decedent's Usuel Occupation	16b. Kind of Bush	ness/Industry										
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212 d with piene piene t tha	3	Owner/Proprietor	Retail S	tore										
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shou ond M	19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Nu	imber or Rural Route Number, City or Town, St	ate, Zip Code)										
CENL	Diane Selby, Wife	407 Chestnut Aver	nue, Washington Grove	MD 20880										
other t		Place of Disposition (Name of cemetery, cremetory or other place)	Date 20c Location - C	·										
	145 Burial 2 Cramation 3 Chamovaurom State		Aug 18,											
Baltimore, semit. Pages 1 et popartient of Hea moortant: If Item; any injury or other once.		rest Oak Cemetery		burg, Maryland										
Baltin permit. P Departme Importan any Injur pace.	22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877													
202.0	Harry M. There	10 E. Deer Pa	ark Dr., Gaithersburg	, MD 20877										
	23a. Part 1 Enter the disease, or complications that caused the dea shock, or heert failure. List only one cause on eech line.	th. Do not enter the mode of dying, such	h as cardiac or raspiratory arrest,	Approximate Interval Between										
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/Medical	Immediate Cause (Final disease or condition	ogenic Sho	r k	1 hour										
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cords, P.O. requires that the de been signed by the should be deteched letted by Physic	Part II. Other aignificent conditions contributing to death but not res	suiting in the underlying cause given in P												
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			24a, Was an autopsy	24b. Wara autopsy findings										
ords requires hould be	Diseaso		performed?	available prior to completion of cause										
The law requires that he has been signed page 2 should be completed by				of death?										
= F # 0			1 ☐ Yes 2 No	1 Yes 2 No										
f Vital I ysician: The s certificate director, pag	25. Was case referred to medical examiner?	28. P	Place of Death (Check only one)											
- 5 sp	Hospital.	ER/Outpetient 3 DOA Other: 4	Nursing Home 5 Residence 6 Other	(Specify)										
g P H er th	27. Manner of Death  1 KNetural 5 Dending (Month, Day Year)	28b. Time of 28c. Injury et Work?	28d. Describe how injury occurred	3										
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Division of the or Attending Prise of the deeth.  al Director: After the fed in by the funere Certification:	4 Homicide building, etc. (Special	19)	City or Town, State)											
spita lours Neral fille	29a. Certifier 1 Certifying Phyelclan: To the best of my know	owledge, death occurred at the time, date	e and place, end due to the cause(s) and mann	ner as stated.										
Division or To the Hospital or Attending Physipin 24 hours efter deeth. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	(Check only 2 Medical Examiner: On the basis of examination and manner stated.													
Me of the	29b. Signature and title of certifier	29c. Licensa numb	per 29d. Data signed (	(Month, Day, Year)										
F 3 F 8	Det 1 10 m	797												
1>	Moven & Love MD	113	Hugust	15 1998										
	30. Name and eddress of person who completed cause of death (ite	m 23a) (Type, Print)	Thora Road Ro	1 '11 MI										
	Robert Li Gold	15225 Shady C	shove Koad Ko	ckrile, id										
State	31. Date filed (Month, Day, Year) 33. Registrar's Sign	g. sports												
Registrar	AUG 1 8 1998	1- 1-1-0												



State of Maryland / Department of Health and Mental Hygiene

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		CYNTHIA YOUN	C CCLIT	LLING			Month	Dey Yes	ar
/Medic		4a. Facility Name (If not institution, giv				4b. City, Town, or	August	13, 1998 4c. County of De	12:15 AM
Examir	ier								
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Funeral Director			I□M 2⊠F	82	Yrs. Months Day				Birthplaca (State or Foreign Country) Pennsylvania
anytand show dat		10a. Stata 10b. County		10c. City, Tow	n or Location		-		10d. Inside City Limits
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or 2	Sire	10e. Street end Numbar			10f. Zip Code		1	0g. Citizan of Whet	Country?
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end saith 7.27 er tr		Cynthia S. Quarto	- daughte		7 Courtland		Bel Air,	MD 21014	1
of Heal		20a. Mathod of Disposition	1D	20b. Place o cemata	of Disposition (Nama of try, cramatory or other p	lace)	Data	20c. Location - City	or Town, Stete
nit. Pages artment of ortant: If its injury or o		1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Othar (Specification 5 ☐	JHamovai from Stata		p Service (		3/13/98	Towson,	Maryland
Departr Departr Importa any inji		2). Signature of Funaral Sarvice Licer	Memas			rass of Facility McComas esbury Rd		·	P.A. 21009
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Smith Dene '08 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner of Beltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9 193 Maryland Medical /timore University 6 Sex If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 12XM 2□ F 214-28-8759 65 Mar. 8, 1933 Director Maryland Usuel Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 Yes 2 No Directo Maryland Caroline Greensboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? St. Funeral 21639 117 Lincoln USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Rece - American Indien 11. Meritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify þ 3 ☐ Widowed 4 ☑ Divorced **Black** Completed th and Mental Hygiene. 7 Is marked other than "natur traumatic event, the Medical 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "Iry or other traumatic event, tre Mexico. Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Nor Jas Trucking Co. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be 2 William F. Smith Mildred Patterson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 144 Old Forge Dr., Dover, Delaware 19904 William Smith 11 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department 4 ☐ Donetion 5 ☐ Other (Specify) Cokers Cemetery 8/10/98 Greensboro, Maryland 21. Signature of Funeral Sewice Licensee 22. Name end Address of Fecility Bennie Smith Funeral Home P.O.Box 1687, Easton, Maryland 21601 Approximete Intervel Between Onset end Deeth 23a. Page Finds are disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final Muorardia disease or condition resulting in deeth) Examiner Examiner physician and the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Records, P.O. Box 68760 Physician/Medicai Due to (or es e consequenca of): 60 for use as signed by the a Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably Wunknown by 24b. Were eutopsy findings evailable prior to Completed 24a. Wes an eutopsy performed? completion of cause of deeth? this certificate has 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1□ Yes > No 2 28e. Dete of Injury (Month, Dey Year) funeral Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the ceuse(s) end menner es steted. 2 Medical Exeminer: On the best of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Dey, Year)

preted cause of death (Item 23e) (Type, Print)

32. Registrar's Signature

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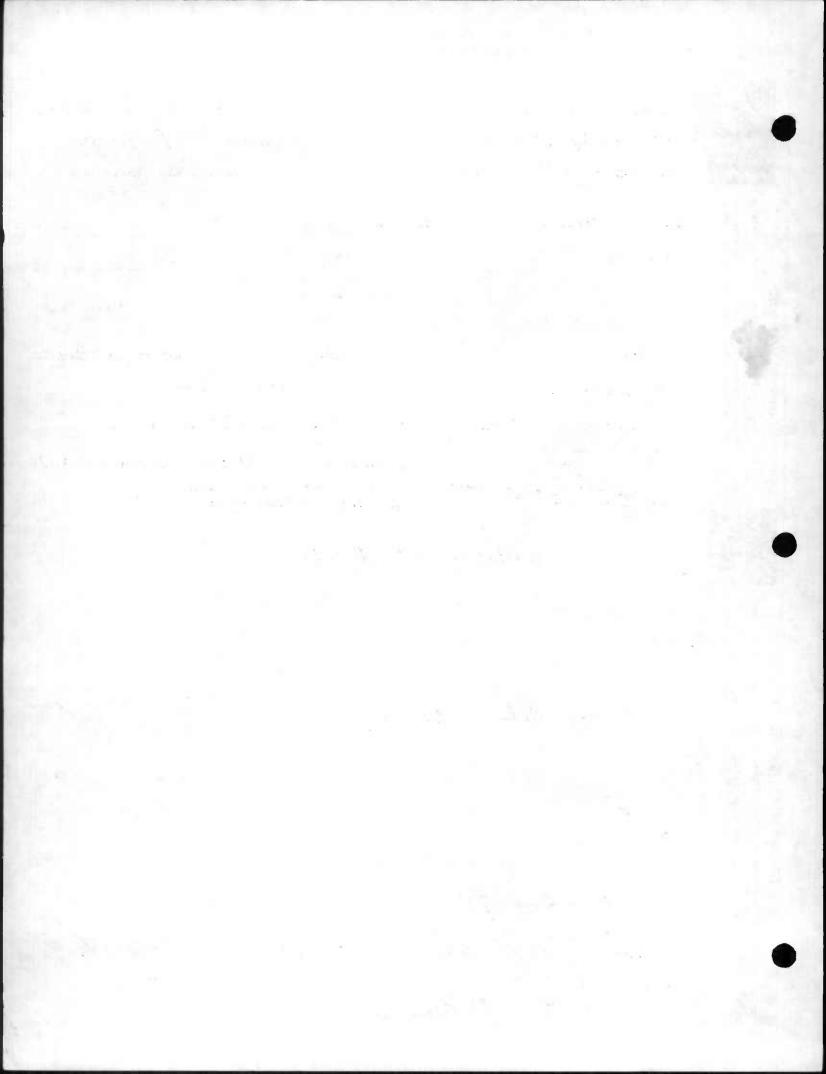
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State Registrar 30. Neme end eddress of person who com

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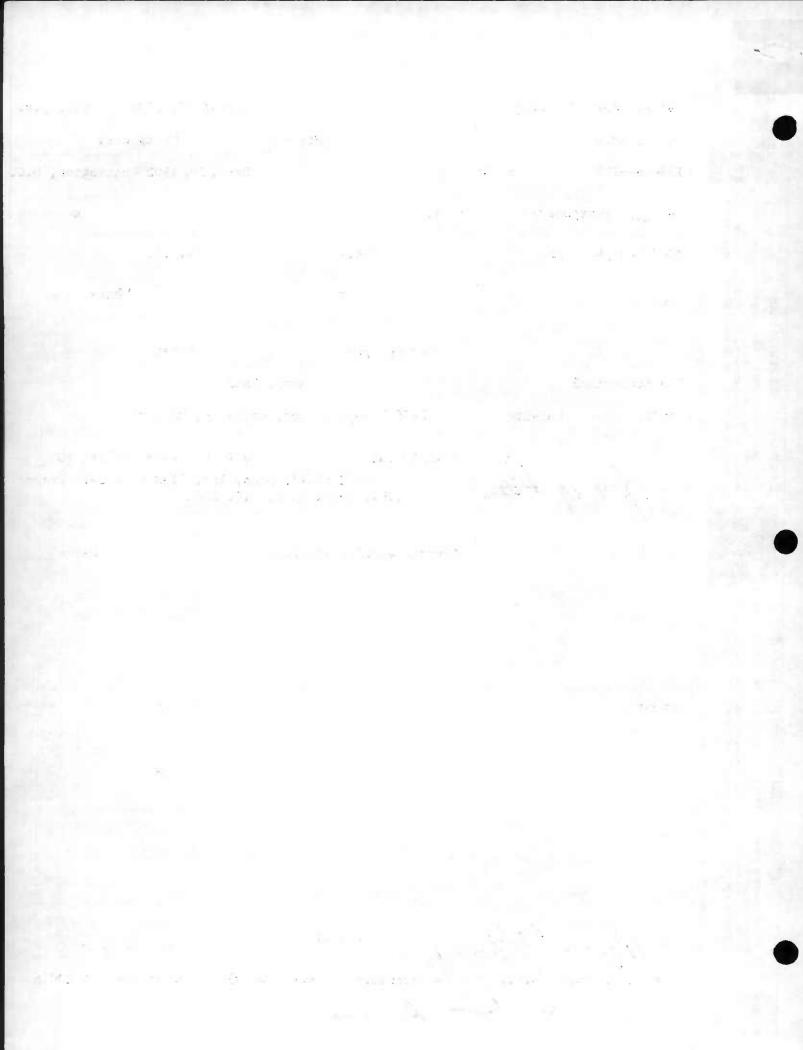
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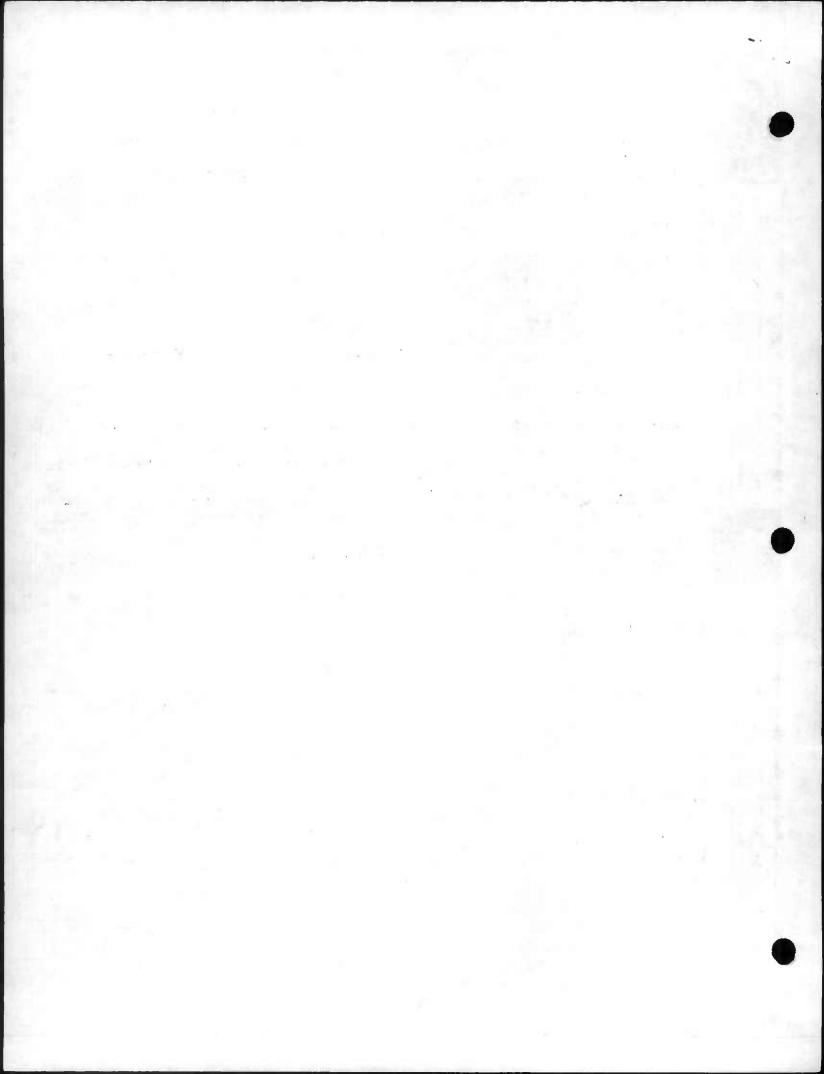
State of Maryland / Department of Health and Mental Hygiene

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Initiated events Iting in daath) Last			Dua to (	or as a conseq	uance of):								
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State of Maryland / Department of Health and Mental Hygien	е -	1 (	U

			Ce	rtificate o	f Death		Re	g. No.					
	1. Decedent'e Name (First, Middle, Las	ot)				2.	Dete of Death	1	Vace	3. Time of Death			
Physician	Lillian L. Tarr	nowski					Month ugust	Dey 15, 199	Year 98	9:20AM			
/Medical Examiner	4a Fecility Name (If not institution, give				4b. City, To	own, or Locat		4c. County		7.20111			
Examiner	804 East Jeffers	on Street			Roy	ckvill	6	Mon	tgom	erv			
Funeral	5. Social Security Number 6. Se		. last birthday)	If Under 1 Ye	ar If Under	24 Hrs. 8.	Date of Birth		9. Birthp	lace (State or Foreign			
Director	091-03-7160 Usuel Residence of Decedent	□M 2\\ F 89	Yrs.	Months Day	ys Hours	Min.	(Month, Dey,	28, 1908	New				
a Bu	10a. State 10b. County	10c. C	ity, Town or Le	ocation					1	0d. Inside City Limits			
the Maryland 28a-f show notified at sector	Maryland Montgon	erv F	Rockvil	10						1 X Yes 2 □ No			
or 28s-f s be notified Directo	10e. Street and Number	icly	CCRVII	10f. Zip Code	8		10	g. Citizen of W	hat Coun	try?			
E Paris	90/ E+ 1-66	C		200	E 0			United States					
na 2 ma	804 East Jeffers	12. Was Decedent Ever in I	J.S. 13.	Wes Decedent of		rigin? (Specif	v Yes or No-			an Indian,			
Maryland 21215-0020 of 2 should be titled within 72 hours after death with the Maryla th 2 should be titled within 72 hours after death with the Maryla II is resistant by the III is resistant event, the Medical Exeminer must be notified at the II to Be Completed by Funeral Director	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:		If Yes, specify C 1 ☐ Yes 2 🔏 N	uban, Mexica	n, Puerto Ric	an, etc.)	Specify:	c, White,	ite			
De sales		ucation	16a. Dece	dent's Usual Oc	cupation	_	1	6b. Kind of Bus					
I 21215-0 ed within 72 to ygiene. wer than 'neturn A, the Medical.	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work do DO NOT use ret	ne during mos ired)	st of working							
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ylan Wental Mental Mic ew To B	Michael Lavin				He	len		not a	vail	able			
The state of the s	19e. informent's Neme/Relationship (7	ype, Print)	19b. Meili	ng Address (Stre	eet and Numb	er or Rural R	loute Number,						
and 2 : and 2	Robert J. Wallace	/nenhew	PO	Box 128	S+i11:	maadaw	Bride	nort V	o rmo	nt 05734			
other to	20a. Method of Disposition	0.05	Diago of Diago	neiting /Alama of			D-4-	Oc. Location - (					
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permit Page Department o Important it i any Injery or	Barbara JoM	2 M. 11/11	R Care	Robert A.	Pumphrey	Funera	1 Home/1	Rockville	e, Ind	c. d 20850-2805			
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the dee	th. Do not en	ter the mode of o	tying, such as	s cardiac or re	aspiretory erre	st,		Approximate interval Between			
Physician										Onset and Death			
/ /Medical	Immediate Ceuse (Finel disease or condition as OVALIAN CARGNOONA												
Examiner	disease or condition rasulting in death)  Due to (or as e consequence of):												
je l				120.000 0.7.									
b8/b0, firete be executed physicien end st the bunal-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
X 68/60, sertificate be ex- ding physicien se es the buna Medical E	Cause (Disaasa or injury that initiated evants resulting in death) Lest  Due to (or es a consequence of):												
that the deeth cert ed by the attendin detached for use									1				
of by the detached	Pert II. Other significant conditions co	ontributing to death but not re	sulting in the u	inderlying cause	given in Part	1.				the cause of death?			
P detay							1 □ Ye	8 2 No	3 Prol	bebly 4 Unknown			
cords requires been sign should be							24a. Wes an perform		ev	ere autopsy findings eilable prior to mpletion of cause death?			
The law te hes sege 2 comp							1 ☐ Ya	s 2 XNo	10	Yes 2□ No			
vital index	25. Was case referred to medical				26. Plac	e of Death (C	Check only one	a)					
OI VITA Physician: r this certific aral director,	examiner?	Hospitel:	☐ ER/Outpatie	nt 3 DOA	Othor			nce 6 □Othe	or (Specif	v)			
Pry Pry T:T	27. Manner of Death	28e. Dete of Injury	28b. Time o	-	njury at Nork?	-		w injury occurre		,,			
ding in Affer funer funer funer	1 Neturel 5 Pending 2 Accident investigation	(Month, Dey Year)	Injury		Work? ☐ Yes 2 ☐	No							
DIVISION OF VITAL HY To the Hospital or Attending Physician: The I within 24 horious after deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	3 Suicide 6 Could not be determined			reet, factory, offi	се	28f	Location (Str City or Town,		er or Rura	al Route Number,			
Stall of Co.													
To the Hospital within 24 hours a To the Funeral Completely filled		reician: To the best of my kn Iner: On the basis of examin end mannar steted.											
To the	29b. Signeture and title of certifier				ense number			d. Date signed					
1	Chair ogen	e M.D.		MA	4245	ر-	a	4057	18,	1558			
96	30. Name and address of person who of		m 23a) (Type,	Print) DV	. CHIT	RA R	AMOPI	T, M.D					
			A	7		7,	~0 20	832					
State Registrar	31. Date filed (Month, Day, Year)  AUG 1 9 199	32. Registrer's Sign	G.	Spork	N								



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 1998 AUGUST Nicholas 16 11:05a 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 24 Hrs If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 10 M 2 F 218-51-1963 Yrs. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2 DNo 10e. Street and Number 10g. Citizen of What Country? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black White, etc. 1 Never Married 2 Married 1 Yes 2 □ No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) TARTAGUA PROPALIS DAVIS IPARENTS. 194. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 BOLLINGER RD. WESTMINSTER, MD 2115 20a. Method of Disposition 1 Burial 2 Cremetion 3 R 4 Donation 5 Other (Specify) 3 Removel from State 21. Signature of Funeral Service Licansee S FUNECAL HOME MD. 21157 Do not only the mode of Avis AND NOTON RA Approximete Interval Between Onset and Death enter the disease, or complications that caused the death, or heart failure. List only one cause on each line. Immediate Ceuse (Finel diseese or condition resulting in death) Comonths 3 months lmonal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Comonths Mon sevietic overa 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 4 Unknown 1 Yes 2 140 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Mnpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

tha death certificate be axecuted bunal-transit ettanding physician the as ed by the ettan O ata has been signed by paga 2 should be detacl requires we After this certificate has The Division of Vital Physician: director, funerel Attending death. To the Hospital or Attendivitin 24 hours after death.

To the Funeral Director: A completely filled in by the forms

Physician/Medical Completed by Be Certification: To Medical

Examiner

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

**Funeral Director** 

Be Completed by

7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Modical Examines must be notified at

permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "I any Injury or other traumrite event, its Men.

**Physician** 

/Medical

Examine

the Meryland

72 hours after deeth

Maryland 21215-0020

Baltimore,

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

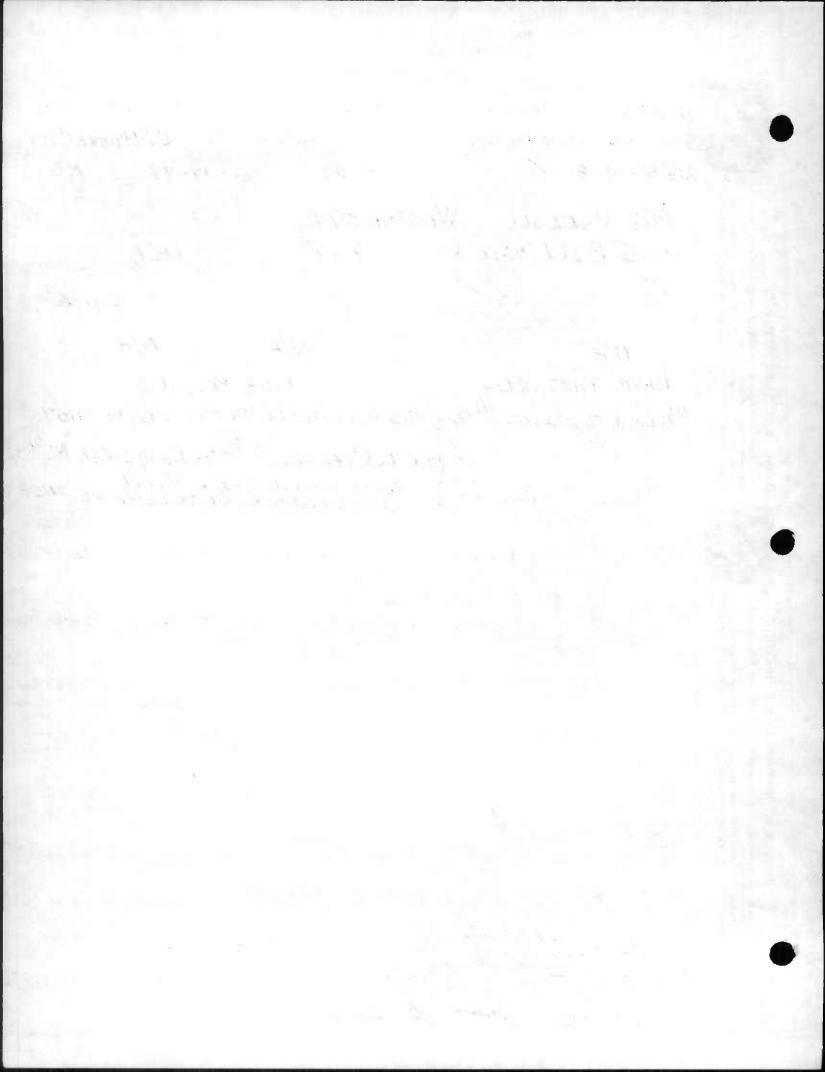
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wolfe Street Hucol CMSC210 Yusan 31. Date filed (Month, Day, Year) 32, Registrer's Signature

State Registrar

AUG 1 8 1998



State of Maryland / Department of Health and Mental Hygiene 98

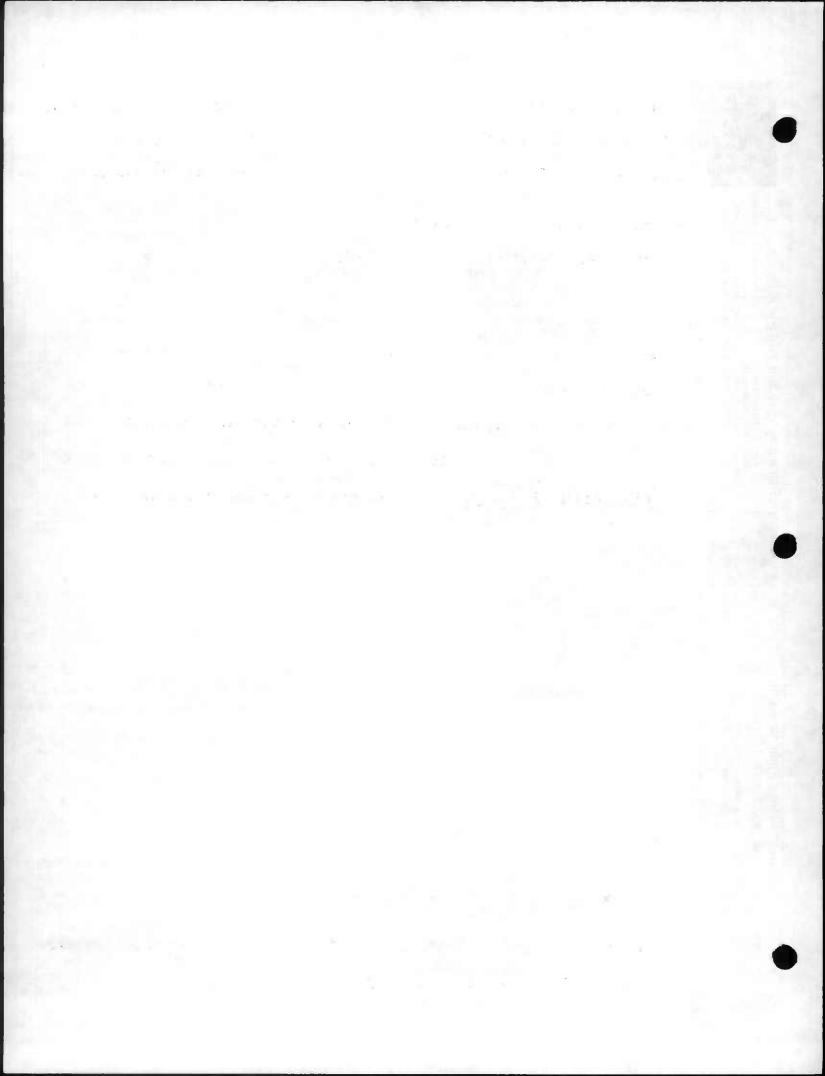
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		1. Decedent's Name (First, Middle	Last)							2. Date of Dec		Vacu	3. Time of Deeth
	sician edical	MARGARET AM	ELIA THO	MAS						AUGUS'	r 20 19	Yeer 998	1:27PM
	edicai iminer	4e Fecility Neme (If not institution, 1 HICKORY L						4b. City, Tov		cation of Deeth	4c. County		
Fune Direc		217-28-8293	6. Sex. 1⊡ M 2 🛣 F	7. Age (In yrs. 72	lest birthday) Yrs.	If Under	er 1 Year Deys	if Under a	24 Hrs. Min.	8. Date of Birt (Month, De) Pebruar	y 17,	9. Birthp Cour Mary.	
nyland		Usuel Residence of Decedent  10e. State 10b. County		10c. Ci	ity, Town or Lo	ocation	, E.					1	0d. Inside City Limits
M H	cto	Maryland Charle	S	L	aPlata								1 Yes 2 □ No
\$ 50 E	Directo	10e. Street end Number				10f. Z	ip Code				10g. Citizen of V	What Cour	ntry?
th w	al [		Apt.#318	3		206	546				US	A	
J within 72 hours after death with the Maryland liena. r than "natural", or items 23a or 28a-f show	by Funeral	3 XWidowed 4 □ Divorced	Armed Fo	2 XNo		Was Dec If Yes, sp 1 ☐ Yes		Hispanic Original Mexicen Specify:	gin? (Spec , Puerto P	cify Yes or No- Ricen, etc.)		e - Americok, White,	
2 ho	i g	15. Decedent			16e. Dece	dent's Us	ual Occu	pation	t of works		16b. Kind of B	usiness/In	dustry
J within Jiana. r than	Completed	(Specify only highes) Elementery/Secondary (0-12) 12	College (1	-4or 5+)	Homei			pation during most ad)	r or workin	ig.	Domes	tic	
Hygie other	Bec	17. Father's Neme (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Meiden Sumerr	10)	
ked o	TOB	William Woodla	nd					Mary	Wood	dland			
s 1 end 2 should be 1 f Health and Mantal I tem 27 le marked of	-	19e. Informent's Name/Relationsh			19b. Maili	ng Addre	ss (Stree	_			er, City or Town,	Stete, Zip	Code)
end 2 s ealth an n 27 le i		Margaret Ann Tho	mas- Dauc	hter	1 Hic	kory	Lane	e Apt.	#318	LaPlat	a, Maryl	and	20646
of Health Item 27		20a. Method of Disposition		20b. I	Place of Dispo	sition (N	ame of		T	Date 998	20c. Location -		
Peges sent of l	5	1 N Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp			cemetery, cree red He				ານຕານຮາ		LaPlata	.Mar	vland
rtan		21. Signature of Funeral Service L		pac				ess of Fecilit		2 20/	201 200	.,	7
Department of Important: If I	DOC	> Lloy 2 M	Este	A						quasco,	,Marylar	nd 20	608
		23a. Part1. Enter the diseese, or a shock, or heart failure. List of	complications that conly one ceuse on e	aused the dee	th. Do not ent	er the mo	ode of dy	ing, such es	cardiac or	r respiretory er	rrest,	i	Approximate Intervel Between
hysici				•									Onset and Death
Medid/ Examir		Immediate Cause (Finel disease or condition	COLC	N CAN	CER							!	
		resulting In death)		Due to (	or es e conse	quence of	f):						
D 15	nju	The second	b										
certificate be executed ding physician and see the buriel-transit	Examiner	Sequentielly list conditions, if eny, leeding to immediate	Sequentielly list conditions, Due to (or es e consections, lend, leeding to immediate										
be ed ician		ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events	C									1	
phys	edicai	that initieted events resulting in death) Lest		Due to (d	or as e consec	uence of	):					i	
	3	d											
e attar	icia icia	Part if Other clanificant condition	e contribution to de	oth but not ro	sulting in the	nderluis	CALLES	von in Dort I		23h Did	Tobacco use co	ntribute *	o the cause of death
y the	hys	Pert ff. Other significant condition	a community to de	etri dut not res	sulling in the U	naenying	ceuse g	venin Peni.					o the cause of death bably 4 - Unknow
5 5 5	by d								_				
been significant										24a. Wes perfo	en eutopsy rmed?	ev	ere eutopsy findings eilable prior to
200	0											00	mpletion of ceuse deeth?
	Completed									101	res 2 No	1[	☐Yes 2☐No
certificate	0	25. Was cese referred to medical	- 1 1 4 1 12		~			26. Plece	of Deeth	(Check only o	A-200	1	
s cert	0 0	examiner? 1 ☐ Yes 2 X No	Hospital:	npatient 2	ER/Outpatier	nt 3 🗆 🖸	DOA OI	her:			dence 6 Oth	er (Specia	(v)
= 5	r.	27. Manner of Deeth	28a. Dete	of Injury	28b. Time o	-	28c. Inju				now injury occur		,,
ith. : Aftar	T O	1 Anetural 5 ☐ Pending 2 ☐ Accident investig		th, Dey Year)	Injury	М		ork? ]Yes 2∐I	No				
after death.  Director: After	1	3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Piece	of Injury - At h	nome, ferm, str	reet, facto	ory, office		2	8f. Location (S City or Tox		er or Run	el Route Number,
within 24 hours at To the Funerel D	edical C	29a. Certifier Certifying (Check only one)	Physician: To the xaminer: On the ba	best of my kno asis of exemine ner steted.	owledge, death etion end/or in	n occurre vestigatio	d et the to	ime, date en opinion, deel	d plece, e	nd due to the	ceuse(s) end mo date and place,	enner es s and due t	eleted. the cause(s)
ithin o the	×	29b. Signeture end title of certifier	0.101.7611			2	9c. Licen	se number			29d. Date signe	d (Month,	Dey, Yeer)
<b>≯</b> ⊢ 0	5	> foriel	- M.	160	m		D28				AUGUST		
		30. Name end address of person v	ho completed ceus	e of death (Ite	m 23e) (Type,	Print)							

KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD

State Registrar 31. Dete filed (Month, Dey, Year) AUG 2 4 1998



**Physician** /Medical Examiner

physician and s the bunal-trans

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signed by the eld be detached to

been si

is certificate has t director, page 2 s

this

Affar

To the Hospital or Attendin within 24 hours eftar death. To the Funeral Director: At completely filled in by the fu

Hospital or Attending Physician: 24 hours eftar death.

à

Completed

Be

2

Certification:

edicai

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

natural, or

the Medical

the Menyland

with

death

72 hours efter

Hyglana.

Pages 1 end 2 should be nent of Health end Mantal

27 other 1 or other

SAMUEL A. THOMAS

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as e consequence of)

Hypoteusion

Haurs, 23b. Did tobacco use contributa to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

atrial florillation esur.

Prostbelle antic value or chronic auticoapilation

24a. Was en eutopsy

24b. Were autopsy findings eveilable prior to completion of ceuse of death?

1 TYes 2 No

chrouse 25. Was case reterred to medical examiner?

renal failure

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 No

Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work?

5 Pending Investigation 1 Naturel 2 Accident 3 Suicide

8/16/98 UNK 1 Yes 2 No

Fall 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

286. Location (Street end Number or Rurel Route Number, 50 4 NTalbot St. Michaels, MD

1286. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steled.

29a. Certifier

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

21601

29b. Signeture end title ot certitier

31. Date tiled (Month, Dey, Year)

4 ☐ Homicide

29d. Date signed (Month, Dev. Year)

D 46020

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

506 Idlewild Ave. Syed I. Ali MD

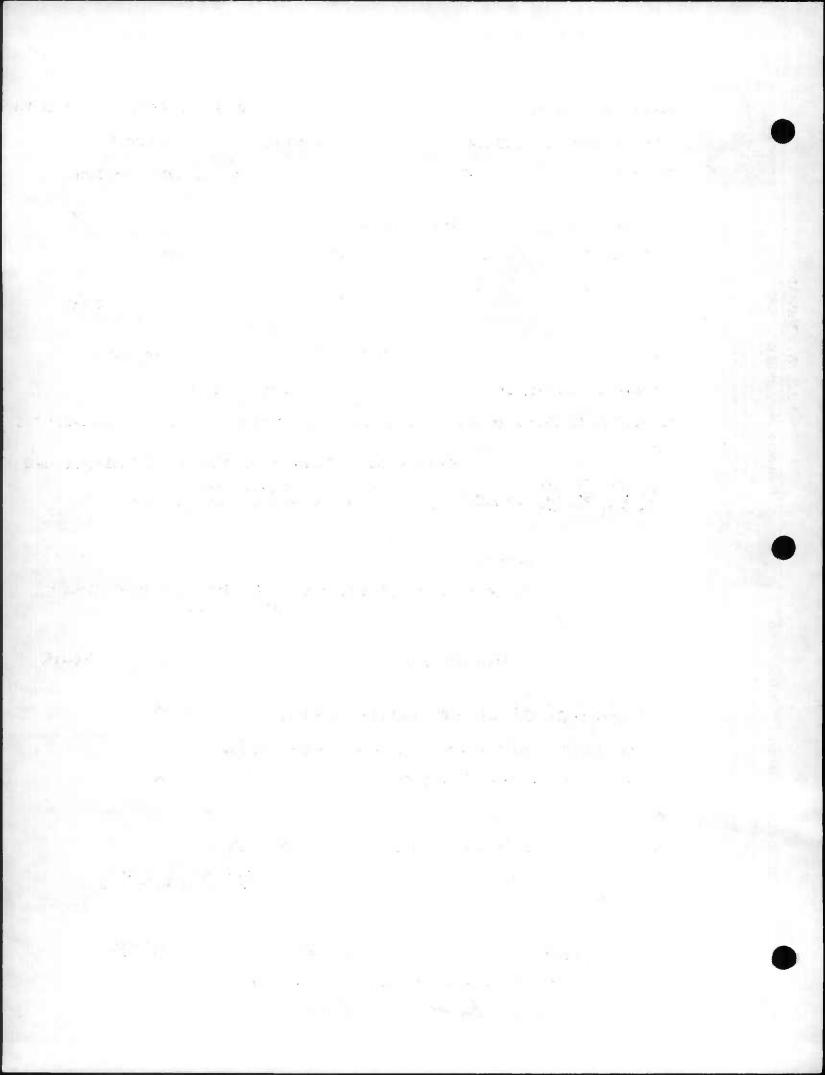
Easton, MD

State Registrar

AUG 2 1 1998

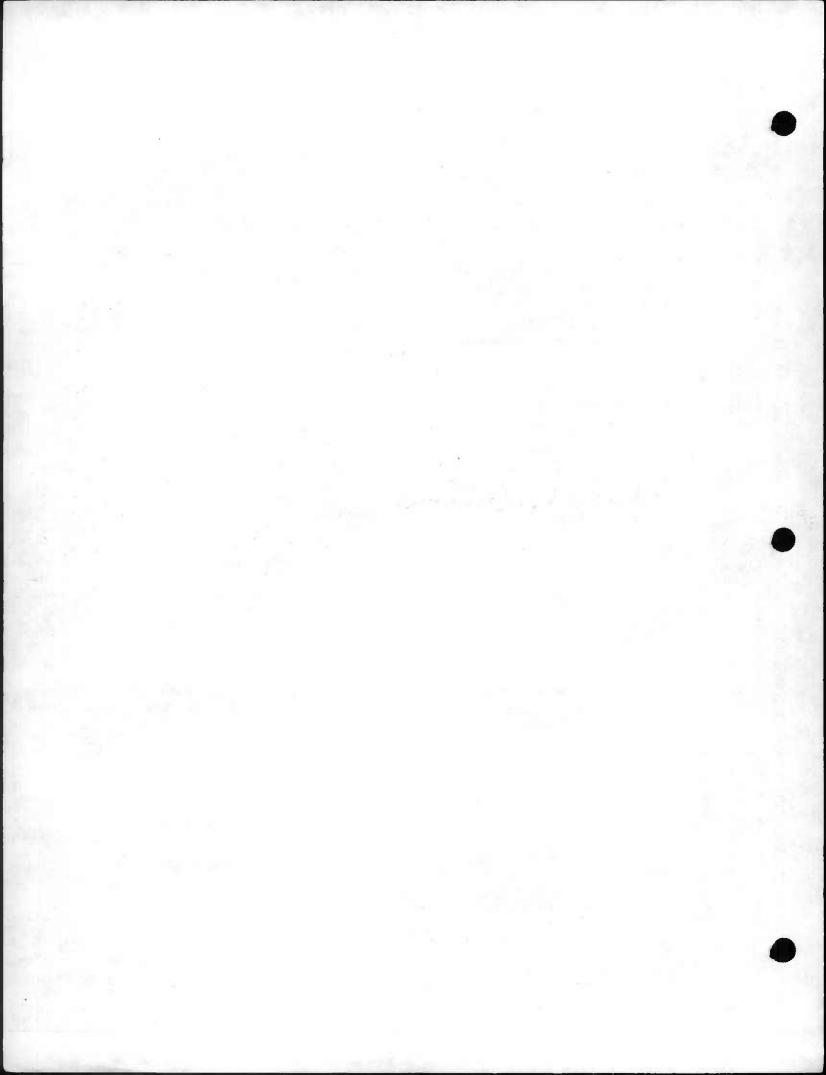


south



State of Maryland / Department of Health and Mental Hygiene

			Cei	rtificate of	Death	B	leg. No.	0	401	03
81	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	th Dev	Year	3. Time of	Death
Physician /Medical	Anne	Elizabeth	Urban			August		1998	6:15	AM
Examiner	4e Facility Name (If not institution, give	re street and number)			4b. City, Town, o	r Location of Death	4c. County	of Death		
	Montgomery Gene				Olney			tgome	-	
Funeral Director	5. Social Security Number 216–44–9395  Usual Residence of Decedent	Sex 7. Age (In y	rs. last birthday) 87 Yrs.	If Under 1 Year Months Days	Hours Mi		, 1911	9. Birthp Cour	place (State of PA.	r Foreign
death with the Maryland rms 23a or 28a-1 show rmust be notified at neral Director	10a. State 10b. County		City, Town or Lo					1	l0d. Inside Ci	
vith the Ma to 28-f a be notified Director	Maryland Montgome	ery	Silver	10f. Zio Code		T 1	l0g. Citizen of V	Vhet Cour	ntrv?	
3a or	3701 Internationa	1 Drive		209	06		United			
frer death v r hema 23	11. Marital Status	12. Wes Decedent Ever in	U,S. 13.			(Specify Yes or No- erto Rican, etc.)	14. Race	e - Americ	can Indian,	
by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 Yes 2 ☑No		eno Fican, etc.)	Specify	k, White, Wh	ite	
od within 72 ho tygiene. Nor then "naturi nt, the treated Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	pation	ent in a	16b. Kind of Bu			
-	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of w	rorking				
Hygian Hygian other the	12		Se	cretary			Federal	Gov	ernmen	t
d oth	17. Father's Name (First, Middle, Last,	)			18. Mother's N	ame (First, Middle,	Maiden Sumam	0)		
should had marked umarked	John 1	Netreba				Elizab			osovsk	i
ges 1 and 2 should be filed within to the theath and Mental hygiene. If item 27 is marked other than or other traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant, the Mental traumatic avant to the Comp	19a. Informant's Neme/Relationship (					Rural Route Numbe				
l and teath m 27 her t	Phyllis Darcy Bar		p. Place of Dispo		ad, Gait					
Sept 70	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cree	matory or other pla			20c. Location -			
Semilt. Pa Separtman mportant: any injury	4 Donation 5 Other (Specif					8/18/98	Silver S	Sprin	ng, Man	ryland
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra page.	21. Signature of Funeral Service Licer	On Culs		2. Name and Address East Dee	1	DeVol Fund Dr., Gait			D. 208	377
	23a. Part1. Enter the disease, or com shock, or heart feilure. List only		eath. Do not ent	er the mode of dyi	ng, such as card	iac or respiratory are	est,	8, 11	Approximet	le
Physician	Silver of the si	e. METAS	24	0.4.4	1.00	20 40	. /	1	Onset and	
/Medical Examiner	Immediate Cause (Final disease or condition	METAS	MIC	CAN	Ctx,	KIMAK	У		year.	2,
	resulting in death)	Due to	o (or es a consec	quence of):		MUNDE	VV			
at sit		b. —						i L		
and I-tran	Sequentially list conditions, if any, leading to immediate	Due to	o (or as a consec	quence of):						
icate be executed physician and street transit sthe burial-transit selection.	Cause, Enter Underlying Cause (Disease or injury	с.						1		
ing physician and east the burist-transit eas the burist-transit Medical Examiner	that initiated events resulting in death) Last	Due to	(or as a conseq	juence of):						
es that the death certificate be executed gned by the attending physician and be datached for use as the burial-transit by Physician/Medical Examil		d						1		
y the ched	Part II. Other algnificant conditions of		resulting in the u	nderlying cause gi	ven in Part I.		obacco use cor			
that ded by date	1 nounc	MM				101	60 2 No	3∐ Pro	bably 4	Unknown
The faw requires that the cate has been signed by the page 2 should be datache.						24a. Wes a perfor		ev	ere autopsy seileble prior to	to
The law page 2						101	es 20 No		death? □ Yes 2 🗹	210
ficeture or. pe	25. Was case referred to medical				00 Dia4 D			1,	105 20	NO
Physician: rihis certific iral director, I: To Be	examiner?	Hospitat: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ot	her _	eath (Check only or Home 5 Resid		(Cassi	6.1	
Physic arthis card dire	27. Manner of Deeth	28a. Date of Injury (Month, Day Year)				28d. Describe h			(y)	
Attending in death.  ector: After by the funa	1 Natural 5 Pending 2 Accident investigation		) Injury		rk? ]Yes 2∐No					
tal or Attanding P rs after death. at Director: After ti led in by the funare Certification:	3 Suicide 6 Could not b determined	e 28e. Place of Injury - A building, etc. (Spe	t home, farm, str acify)	reet, factory, office		28f. Location (S City or Tow		er or Rure	al Route Nun	nber,
To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		ysician: To the best of my k								s)
Med Med	29b. Signature end title b/certifier	and manner stated.	1.14	29c_Lican	re-number		29d. Date signed	d (Month.	Day, Year)	
FIFE		1/1	(IVI)	m	8457	1	72/11/5	10	1000	
	30. Name end address of persen who	completed cause of death (I	tem 23a) (Type,	Print)		171	00031	131	200	
	21 Date filed (Month Par Your	LUIU MUNC	多 Yhu	er 1)12	00	uty i	WD .	10	017	
State Registrar	31. Date filed (Month, Day, Year) AUG 1 8 1991	32. Registrar's Sig	G.	Spark	,					



State of Maryland / Department of Health and Mental Hygiene 26784

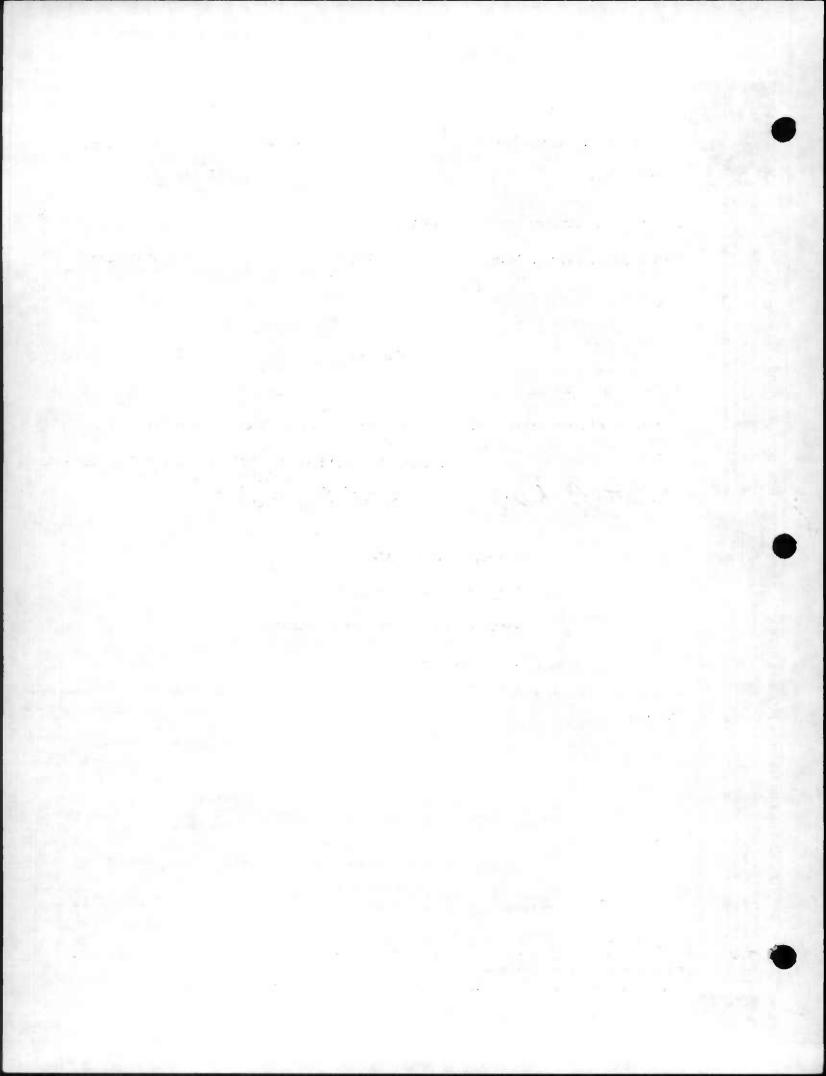
				Cei	rtificate of	Death		Reg. No.		
		1. Decedent's Neme (First, Middle, Last)					2. Dete of De		Vaar	3. Time of Deeth
	Physician	ZENSHU	1 4	NAN	( C+		A V G	Day	Yeer	0330
	/Medical Examiner	4e Fecility Neme (If not Institution, give s SHADY GROVE	THE STATE OF THE S	HOSPI			or Location of Deeth	4c. County	of Deeth	1ERY
	Funeral Director	5. Social Security Number 6. Sec. 215-29-1794	7. Age (In	yrs. last birthdey) 79 Yrs.	If Under 1 Year Months Deys	If Under 24 H	Irs. 8. Date of Bir (Month, De	y, Yeer)	9. Birthpi Coun Chi	lece (Stete or Foreign try)
	_	Usual Residence of Decedent		17		1	oan. Zo	, エフエフ	CIII	.110.
	f show	10a. State 10b. County  Md. Montgom		City, Town or Lo					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	or 28a-1 e	Md. Montgom	lery	Gal	thersburg			10a. Citizen of V	What Coun	tn/2
3	rer ceam with the Marylar frems 23a or 28s-1 show ther name be notified at Funeral Director	911 Bacon Palac	e Crt.			878		Taiw	,	ROC
1	r items 23s	11. Maritel Stetus	12. Wes Decedent Ever Armed Forces?		Wes Decedent of H	lispante Origin?	(Specify Yes or No		e - Americ	
	by I	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:		1 ☐ Yes 2 🖾 No	Specify:		Specify		ian
200-61212	ed within 72 hours ygiene. her than "naturel", ft, the Modical Exe Completed by	15. Decedent's Edu (Specify only highest grede	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of I	working	16b. Kind of Bo	usiness/Ind	ustry
1	Hygiene.  Hygiene.  ont, tre M.  e Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		Pilot			Chin	a Air	force
	ET = A	17. Fether's Neme (First, Middle, Last)				18. Mother's I	Name (First, Middle			20200
	0 5 T B O	UNK.	Wang			1	UNKNOWN			-
3	DE E	19a. Informant's Name/Reletionship (Ty		19b. Meili	ng Address (Street	end Number or	Rural Route Numb		Stete, Zip	Code)
	105	Weina Chow (Daugh	ter)	1600	Howard	Landing	Dr. Gait	hersbur	g, Md	. 20878
	other	20e. Method of Disposition	20	b. Place of Dispo	osition (Neme of metory or other plea	ne)	Dete	20c. Location -	City or To	wn, Stete
	permit. Pages Department of Inportant: If its any injury or of	1 A Burial 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	emoverfrom State	Chin Sha	an Anloyu	an Cem.	8/25/98	Chin S	han,	Taiwan
	Department Page Important: any Injury once.	21. Signature of Funerel Service License	hanter		2. Name end Addre		Chambers e. Riverd			
ı		2 at Pert1. Enter the disease, or complishock, or heert failure. List only or	cetions thei caused the							Approximete Interval Between
P	hysician	allock, of fleet failule. List only of	io couse on occi inte.							Onset end Death
	/Medical	Immediate Ceuse (Finel disease or condition	CEREB	DAI	CONT	TUCC	011			1 1111
E	Examiner	resulting in death)		to (or as e consec		1 001	020			, was
	je je		SUBDO		HEM	ATAM	IA			1 WK
	n and iel-transit	Sequentially list conditions,		to (or es e consec		1010				, , , ,
	uriel-	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	FALL							1 WEEK
	ieruncata be executed ding physician and se as the buniel-transit	that initiated events resulting In deeth) Lest		to (or es e consec	quence of):					. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	attend for us									
	oy tha gached ached	Part II. Other significent conditions con	tributing to death but not	resulting In the u	inderlying cause giv	en in Pert I.				the cause of death?
	- 0 D	RESIDUAL W.	EAKNES.	S,	STROKI	E 3/V	S 10	Yas 2□ No	3 Prot	pably 4 Ninknown
	should should					Xe ji T		en eutopsy ormed?	CO	ere eutopsy findings eilable prior to mpletion of cause deeth?
3	ate has page 2						10	Yes 2 No	10	Yes 2□ No
1	certificate rector, pag	25. Was cese referred to medical				26 Place of I	Deeth (Check only			
	7 TO TO	examiner?	lospitel:	2 ER/Outpatier	nt 3 DOA Oth	ner: _	g Home 5□Resi		er (Specifi	v)
	rthis eral d	27. Manner of Deeth	28a. Date of Injury	28b. Time o				how injury occur		/
	rs effer death.  The first of the funer of t	1 □ Naturel 5 □ Pending investigation	(Month, Dey Yea			Yes 2 No	F-11	W F	SITI	100011
	offer death Director: /	3 Suicide 6 Could not be	28e. Place of Injury	At home, farm, str			28f. Location (	Street and Numb	per or Rure	Route Number,
-	offer Direction	4 Homicide	building, etc. (Sp	pecify)			City or To	wn, Stete)		
lana lina	within 24 hours efter to the Funeral Director Completely filled in Medical Certi	(Check only 2 Medical Examin	cicien: To the best of my her: On the basis of exar		h occurred et the tir					
44	within 2 To the comple	29b. Signeture end tills of peniller	end manner steted.	-	29c. Licens	se number		29d. Dele signe	d (Month	Dey, Year)
F	1 3 - 3	1	(dll)	//	8		100	1	10.	00
1	X	* Cure	rull	7/11	2007	-079		HUG-	18	78
		30. Name and address of person who co	mpleted cause of death	(Item 23e) (Type,	Print)	AR		- 1/1	λ ->	-017
		31. Dete filed (Month, Day, Year)	32. Registrer's S	FERN	W000	MD ASE	MESO	PAIN	D Z	2814
	State Registrar	AUG 1 9 1998			Spark	2				

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State of Maryland / Department of Health and Mental Hygiene

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	1 Donodentia Ma	me (First, Middle,	( act)		Cei	rtificate	of I	Death	2. Date of De	Reg. No.	6.	3. Time of Death
Physician		me (i irai, iviidaio,	Lusiy						Month	Day	Year	
/Medical	Calvin	E. Whale					-		August	T		5:02pm
Examiner	4a Fecility Name	(If not Institution,	give street and nur	nber)			4	b. City, Town, or L	ocation of Death	4c. Cour	ty of Death	
			anch Cour					Sharpsbu			shingt	on
Funeral	5. Social Security	Number 6	S. Sex 1⊠ M 2□ F	7. Age (In yrs.		If Under 1 Months   [	Year	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Count	lace (State or Foreign try)
Director	578-30-		IMW ZUT	91	O Yrs.				April 1	8, 190	8 Mary	land
or 28a-f show De notified at	Usuel Residence 10a. State	of Decedent 10b. County		10c Ci	ty, Town or Lo	cation					10	0d. Inside City Limits
r 28a-f show notified at												1 ☐ Yes 253 No
or 28a-fa	Maryland	-	gton	S	harpsbu	1						
or 2	10e. Street and N	lumber				10f. Zip Co	ode			10g. Citizen o	f What Coun	try?
		eral Bra	nch Cour			2178				United		
r Items 23d	11. Marital Status		12. Was Dece Armed Fo		I,S. 13.	Was Deceder If Yes, specify	nt of H	lispanic Origin? (Span, Mexicen, Puert	pecify Yes or No o Ricen, etc.)	- 14. R	ace - America lack, White, o	
		rried 2 Merrle	d 1 ☐ Yes If Yes, Giv	215 No		1 ☐ Yes 2 ☐				Spec		
Exal.		4 Divorced	Year or Da							- Open		nite
nt, the Medical	(Sp	15. Decedent's ecify only highest			(Give	dent's Usual (	done i	during most of wor.	king	16b. Kind of	Business/Ind	dustry
- Men	Elementary/Se		College (1	-4or 5+)	life.	DO NOT use	retired	d)				
that o	12				Ma	nager				Montgo	omery	County
d other event, t	17. Father's Nem	e (First, Middle, La	ist)					18. Mother's Nan	ne (First, Middle	Maiden Sum	ame)	
marked o	William	Oscar Wh	alen					Grace C	rown			
		Name/Reletionshi	(Type, Print)		19b. Mailir	ng Address (S	Street	and Number or Ru	ral Route Numb	er, City or Tow	m, State, Zip	Code)
- CV -	Judith M	. Wilson	(Daught	er)	5018	Genera	1 F	Branch Co	urt. Sh	arpsbu	rg. MD	21782
E E	20a. Method of D		,		Plece of Dispo cemetery, crea	sition (Name	of	na)	Dete	20c. Locatio		
= 5		2 ☐ Cremation 3 5 ☐ Other (Spe	Removal from	State				Park	9/17/09	Poolerri	110 N	fary land
Important: any Injury ance.		Funegal Service Li		ra				ss of Facility De				laryrand
any l	ZI. Signaturg of	1-0	han					er Park		star no	III C	
	V Cu	eus C	·					rg, MD 20				
physician and is the bunal-transit edical Examiner		conditions, immediate dertying or injury		estive Due to (	Heart or as a consect Sever	Failur quence of): e Aort		Stenosis	6			
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for usa			d. Card	Tomyopa	LILY					-		
igned by the attending be datached for usa by Physician/N	Part It. Other stgr	nificant condition	s contributing to de	ath but not res	sulting in the u	nderlying cau	se giv	ven in Pert I.	23b. Did	tobacco use	contribute to	the cause of death?
ed by the a datached to Physic									10	Yes 2 N	3 Prot	babty 4 Unknow
be da	Depress	sion										
										en eutopsy	24b. We	ere autopsy findings ailable prior to
should should									pen	ormed?	co	mpletion of cause death?
cate has been s paga 2 should Completed									40	- TST AL		
r, paga										Yes 2 No	1	Yes 2 No
director, pag			Hospital:				Ott	26. Place of Dea				
ig d			101		ER/Outpatier			4 Li Nuising n	lome 5 K Resi			у)
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tha tha	2 ☐ Accident 3 ☐ Suicide	investiga	t be go Disco	of Inline At 1	omo forma si			193 2 1140	28f Location	Street and No	mher or Pare	al Route Number,
Director:	4 ☐ Homicide		200. FIZUE	of Injury - At h	nome, farm, str fy)	reet, factory, o	office		City or To	wn, State)	mber or mura	ii noule ivamber,
une Bly fil	29a. Certifier (Check only							me, date and plece				
		7	and man	er stated.								
To t	29b. Signature ar	nd title of certifier	,	^		29c. l	Licens	se number		29d. Date sig	ned (Month,	Dey, Year)
D	1	for	te		im.T	2 0	411	31		August	14. 1	1998
	30. Name end ag	dress of person w	no completed caus	e of death (Ite	m 23e) (Type.					11ugust	. 1-19	2770
							lagi	erstown,	MD 2174	0		
State	31. Date filed (Mo			egistrer's Sign		,	-0	,				
State		1 0 46	100		MA.		4					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 17 Elizabeth Willig August 1998 8:30pm /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daeth 4c. County of Death **Examiner** 4242 East West Highway #303 If Under 1 Yeer if Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
October 15, 1911 Montgomery 9. Birthplaca (Stata or Foreign Country)
Russia 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 25 F 410-52-5643 86 Yrs **Director** Usuel Rasidance of Decedan with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No NY Director Erie Amherst 10e. Street and Number 10f. Zip Coda 10a. Citizen of Whet Country? 10 Amsterdam Apt. 7 14226 USA Funeral deeth 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, White, atc. filed within 72 hours efter 1 Navar Merried 2 Married 1 ☐ Yas 2 € No 1 Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0020 þ 3€ Widowed 4 □ Divorced Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry I Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) Bookkeeper Accounting other tem 27 is marked other other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumama) . Pages 1 end 2 should be fill ment of Heaith end Mentel H lant: If Item 27 Is marked oth in end Mentel F. Be George Cherner Anna Rose Kaprow 0 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Sharon Willig - Daughter 4242 East West Highway #303 Chevy Chase, MD 20815 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 5 permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) Holy Order of Living 8/19/98 | Buffalo, NY 21. Signatura of Funaral Sarvice Licensaa 22. Name and Addrass of Facility Danzansky Goldberg Memorial Chapels, INC Den 1170 Rockville Pike - Rockville, MD 20852 23a. Part1. Britar tha disaasa, or complications that ceusad tha death. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart faiture. List only one cause on each line. Approximate intarvai Batween Onsat and Death **Physician** Immediate Cause (Finat disease or condition rasulting in death) /Medical Gastrointestinal Hemorrhage **Examiner** Dua to (or as a consequence of) Examiner Gastric Cancer that the death certificete be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaase or injury that initiated avents resulting in daath) Last physician end the buriel-tran Due to (or as e consequence of) P.O. Box 68760 Physician/Medical Due to (or as e consequence of) 98 USB 0 ed by the e Part ti. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably A Unknown been signed to Records, by 24b. Ware autopsy tindings eveilable prior to complation of cause of daeth? 24a. Wes an eutopsy Completed hes page 2 1 ☐ Yas 2 ☐ No 1 ☐ Yes XX No certificete Division of Vital Attending Physician: director, Be 25. Was cesa rafarred to medicet 26. Placa of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidence 6 MOthar (Specify) Home axeminar? 2 1 Vas 2 No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mannar of Daath 28a. Data of injury (Month, Day Year) 28c. injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of After 1 Naturei 5 Pending injury deeth. 1 Yes 2 No invastigation 2 Accident Hospital or Attend 24 hours efter deeth Funeral Director: 6 Could not ba 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) à 4 - Homicida 24 hours e To the best of my knowledge, death occurred et the time, dete end plece, and dua to tha causa(s) and menner es steted.

Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and manner stated. 29a. Certifian Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature of 29d. Data signed (Month, Day, Year) 29c. Licansa number 10 August 20, 1998

State Registrar 30. Nama and addrass of person who completed causa of death (itam 23a) (Typa, Print)

#820 - Chevy Chase

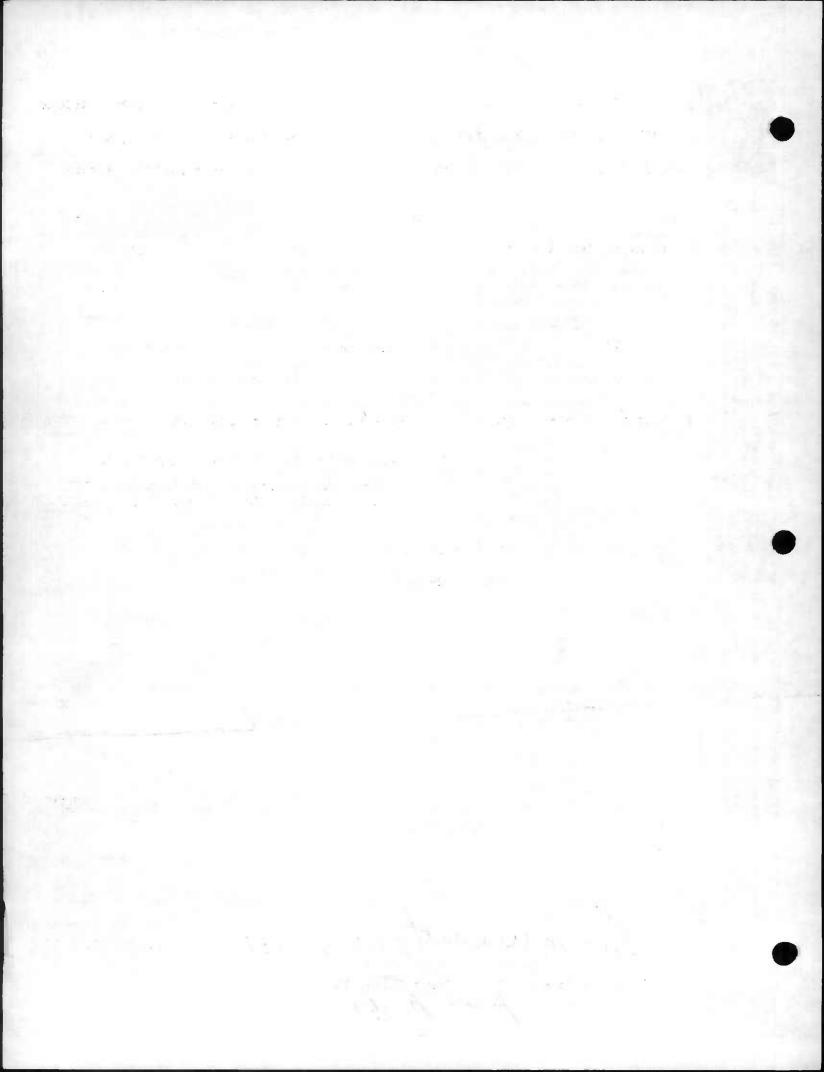
32 Ragistrar's Signatura

MD 20815

5530 Wisconsin Ave.

AUG 2 0 1998

31. Data filad (Month, Day, Yaar)



		Decedent's Nama (First, Middle, Last)									2. Date of De	3. Time	of Death				
ш	Physician /Medical	MAX EUCENE MEDDLE								AUGUST 19 19			10:	04AM			
6-	Examiner	4a Facility Name (If not institution, give street end number)  4b. City, Town, or Lo								ocation of Death	cation of Death 4c. County of Death						
		MEMORIAL HOSPITAL EASTON									TALBOT						
	Funeral		5. Social Security Number 6. Sex XX M 2 F 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.								8. Date of Birth (Month, Dey, Yeer) 9. Birthplaca (State or Foreign Country)						
	Director	325-18-1623 AMA 2LIF 80 Yrs. Usual Residence of Decedent									OCT. 2	25, 1917	KA	NSAS			
	gand iand	10a. State	10b. County	10c. City, Town or Location									1	0d. Inside	City Limits		
	Mery rish tor	MD	TALB	OT	r ST. MICHAEL				5						1 X Yes 2 □ No		
	r 28e	10e. Street and Nu	ımber	.,	1			10f. Zip Coda				10g. Citizen of	What Cour	ntry?			
	th with the Merylar 23a or 28a-f show ust be noutred at rai Director	1030 RI	VERVIEW T	ERRACE			21663					USA					
	offer deeth with the Me of recognition of 25a-1 so where must be profited Funeral Director	11. Marital Status	015,116,1	12. Was Decedent Ever in U,S. Armed Forces?		13. Was Decedent of Hispar     If Yes, specify Cuban, M			lispanic Orl	spanic Origin? (Specify Yas or No- n, Maxican, Puarto Rican, atc.)			14. Race - Americen Indian, Black, White, etc.				
0	or items or items or items or items	1 ☐ Naver Marriad 2 ☒ Married		1 XYes 2 No If Yes, Give Year or Dates:		1□Yes 2\X\No					, nour, ato.,	Specify: WHITE					
21215-0020	n 72 hours effer deeth with the Meryland *natural*, or frems 23a or 284-f show solical Examiner must be notified at leted by Funeral Director	3 Widowed 4 Divorced															
15-	led within 72 ho lygiene. Ner than "neture It, Ir. Medical Completed	(Spe	15. Decedent's Edu cify only highest grad	icetion le com <i>pleted)</i>	le completed)		6a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT usa retired)			t of work	ing	16b. Kind of Business/Industry					
112	should be filed within and Mentel Hygiene. marked other than " impatic event, tre Mex To Be Comple		Elementary/Secondary (0-12)		or 5+)	MILITARY			·			U.S. GOVER		NMENT			
	be filed d other event, I Be Cc		17. Father's Name (First, Middle, Last)		-0-		TITLE TIME			er's Name	e (First, Middla,	irst, Middla, Maidan Sumeme)					
lan	Mentel Mentel arked o	JAMES E	EDWIN WEDD	E					LERA	SUI	HERLANI	HERLAND					
ē	2 should be end Mentel is marked o summetic ever	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Straet end Number or Ru							er or Run	el Routa Number, City or Town, Stete, Zip Code)							
	i and 2 Health e em 27 ls	JESSIE G. WEDDLE/ WIFE 1030 RIVERVIEW TERRACE									, ST. MICHAELS, MD 21663						
O	2007	20a. Method of Dis	1	Ramoval from Stat	cem	etery, crei	osition (Nem metory or o	thar ple			Date	20c. Location			l.		
Ë	Partition Partit		1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)										8-20-98 CHESTER, MD				
Sall	permit. Pe Departmer Important: any injury once.	21. Signatura of Fi	uneral Savice Licens	ee 70	-1-0				ess of Facili		& NEWN	AM FUNER	ΔT. H	OMF	РΔ		
	40 E 4 d	111/2	News	æm .	CFSP	200	0 S. 1	HARR	RISON	ST.,	EASTO	, MD 21		orin,	1 • 11 •		
		23e. Part1. Enter shock, or hea	tha disease, or comp art failure. List only o	lications that caus ne cause on eech	ed the death.	Do not en	ter the mod	e of dyir	ng, such as	cardiac	or respiratory a	rrast,			Between		
	Physician	A 1 1								Onset and Death							
1	/Medical Examiner	Immediate Ceuse disaasa or condition resulting in death)	on	CENERIUS							92°			0			
		I roodking wit dodkiny	Due to (or as a consequence of):														
	th certificate be executed tending physician end or use as the bunat-transit an/Medical Examiner	W. C.		b									<u> </u>	_			
ć	ath certificate be executed trending physician end or use as the buriat-transit lan/Medical Examir	Sequentialty list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury c.															
68760,	yslcia ys bu	that initiated events															
89	Med Triffica	resulting in death)	esulting in death) Last														
Вох	atth certificata attending phys for usa es the clan/Medic			d													
	the at the at the A fc	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part f.								23b. Did tobacco usa contribute to the cause of death?							
P.0	The lew requiras that the day the less been signed by the a page 2 should be datached to completed by Physic								1 Yes 2 No 3 Probably 4 Unknow								
S,	signe d be d									24a. Was an autopsy 24b. Wara autopsy fin			ev findinge				
Or	requ should										perfo	med?	av	aitable prompletion	ior to		
Records,	has the pe 2 s											of death?					
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Division of Vital	certifi rector	25. Was cese refe examiner? 1 Yes 2		Hospital:	ODES	2/0	- 2C DC	Oth	har		h (Check only o		(C	6.1			
	Attending Physician: r death. sctor: After this certific by the funeral director, Iffication: To Be (	27. Manner of Dea		28a. Date of Injury 28b. Time of 28c. Injury at							me 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how Injury occurred						
ion	ath. e fun	1 Natural 2 Accident	5 Pending investigation	(Month, L	Dey Year)				rk≀  Yes 2□	No							
vis	Attendi or death octor: A by the f	3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	d 286. Place of injury - At nome, farm, street, factory, off			, office	28f. Location			on (Straet end Number or Rural Route Number, Town, Stete)						
Ö	safe of in Cert	40110111010		building, etc. (Specify)							ony or rown, crotor						
	To the Hespital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification: 7	29a. Certifier (Check only  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)															
1	within 24 To the F complete	one)	-	and manner							od at the time,						
	or vit	29b. Signature and title of certifier								29d. Data signed (Month, Day, Year)							
		) (Kuhiom) D 52856							0/14/48								
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  CYNTHIA RUBIO, M.D., 219 S. WASHINGTON ST., EASTON, MD 21601															
		CYNTHIA  31. Date filed (Mor			S. WASH strar's Signatur		UN ST	., F	SASTON	, MI	21601						
	State Registrar		UG 2 0 199		strar's Signatur		So		,								
DHM	IH 16 Rev 6/95		0 100			1.	100	ak	2/	_							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

gradu. 

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Tima of Death Month **Physician** Yaar Herman Paul Walters 15, 1998 /Medical August 2:30 PM 4a. Fecility Nama (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 22052 Main Street Hillsboro Caroline If Undar 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) **Funeral** Days 12 M 2 □ F Yrs. Director 68 May 2, 1930 Maryland 215-26-5529 Usual Residence of Decedant the Meryland 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yas 2 No Director Maryland Caroline Hillsboro 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 22052 Main Street Funeral 21641 United States 12. Was Decedant Ever in U,S.
Armed Forcas?
15 Yas 2 □ No US Navy
17 Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) Race - American Indian, Biack, White, etc. 11. Marital Status 72 hours after 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 1952 Caucasian Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiane. Important: If Item 27 is marked other than any Injury or other traumests. Elementary/Secondary (0-12) Collaga (1-4or 5+) 10 Truck Driver Food Distribution 17. Father's Name (First Middle Last) 18. Mothar's Nama (First, Middle, Meiden Sumama) Be Ear1 Walters James Edith Magdalene Worth 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Anna J. Walters Wife 22052 Main Street, Hillsboro, Maryland 21641 20b. Place of Disposition (Nama of cematary, crematory or other placemetery) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) /19/98 St.Paul's Episcopal Church Hillsboro, Maryland 21. Signatura J Funaral Sarvice Licensas 22. Nama and Address of Facility Moore Funeral Home, P.A. loone 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one ceuse on each line. Approximate Interval Batween Onsat and Death Physician /Medical Immediata Cause (Final diseasa or condition resulting in death) **Examiner** Examiner the burial-transit certificate be executed Saquantially list conditions, if any, laading to immadiata causa. Enter Underlying Ceuse (Diseasa or Injury that initieted avents rasulting in death) Last end Dua to (or as a consequence of): Box 68760, physiclan Physician/Medical Dua to (or es e consaquance of): usa as P.O. I Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Records, þ 2 pege 2 should Completed 24b. Ware eutopsy findings available prior to 24e. Was an autopsy peen complation of causa The law of deeth? 1 Yas certificate Division of Vital To the Hoapital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was casa ratarrad to madical Be 26. Placa of Daath (Check only ope) Other: 4 Nursing Home 5 Rasidance 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Panding investigation 1 🗌 Yas 2 🗌 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicida 12 Cartifying Physician: To the best of my knowladga, death occurred et tha time, data and piece, end due to the ceusa(s) and mannar as statad.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and piece, end due to the ceuse(s) end mannar stated. 29a. Certifiar Medical (Check only 29b. Signature end titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Yeer) 30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print) 205 DI &

**DHMH 16 Rev 6/95** 

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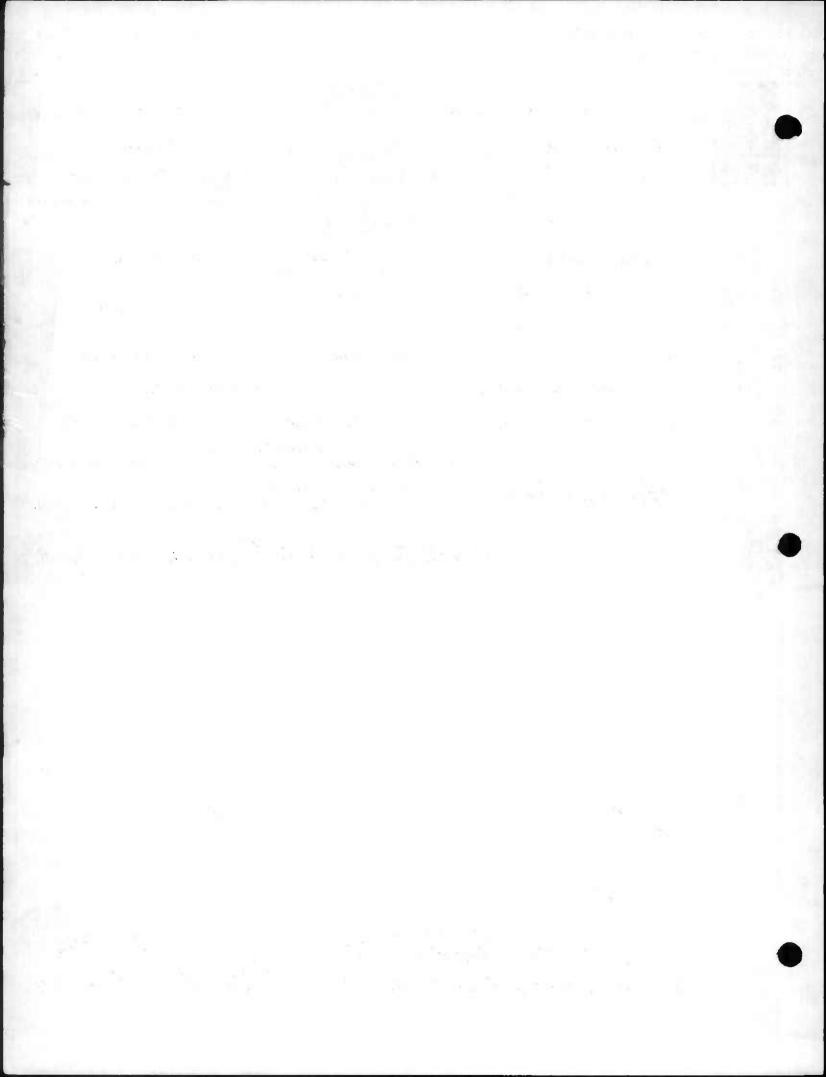
Registrar

31. Deta filed (Month, Day, Yaer)

AUG 2

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32. Ragistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 23 **Physician** 8:40 Pm arleton 98 /Medical Fecility Neme (If not institution, give street and number 4b. City, Town, or Location of Deeth Examiner Hospital

7. Age (In yrs. last birthday) Lantic General 9 Birtholace (State or Foreign 5. Social Security Number **Funeral** Months Deys Hours 1 M 2□ F 221-05-4304 Director Usual Residence of Decedent 10d. Inside City Limits 10a\_State 10c. City, Town or Location 1 Yes 2 No over Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ed other than "natural", or hems 23s or event, the Medical Examiner must be n 46 Nerne 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Deves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Spacify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Maritat Status Black, White, etc. 1 ☐ Never Married 2 Married specity: white 1□ Yes 2MNo Specify 3 ☐ Widowed 4 ☐ Divorced þ Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retiged) 15. Decedent's Education (Specify only highest grede completed) wholesale Elementery/Secondery (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) ahould be Mantal 19a, Informant' (Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 推 46 Kodnec Pages 1 and 2 Ligunia Separtment of Health reportant: If New 27 20b. Place of Disposition (Name of 20a. Method of Disposition

1 △ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, Sta 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses unua 3radtord Dover 23a. Pert1. Enter the disease, of complications that caused the death. Do not enier the mode of shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsel and Death **Physician** /Medical Immediate Ceuse (Final near disease or condition resulting in death) **Examiner** Physician/Medical Examiner ettanding physician and for usa es the bunal-tran Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury certificate be That initiated events resulting in death) Last Due to (or as a consequence of): es l 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed by CO 100 casen 24b. Were autopsy findings aveilable prior to completion of cause ot deeth? Completed 24a. Wes en eutopsy 2 PNo 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA efter death. Director: Aftar this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division Attending 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 4 Homicide ŏ To the Hospital within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner es steted.

2 Madfcat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ohysicii-

State Registrar 31. Date tiled (Month, Day, Year)

AUG 2 5 1998

30. Name and adduces of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrar's Signature

or water learning Antonia piecete telepete telepete especialistic He reduced for 

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

To the Hosp within 24 hor To the Fune completely f

31. Dete filed (Month, Day, Year) State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signeture end title-of certifier

29c. License number

O.C.M.E

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated.

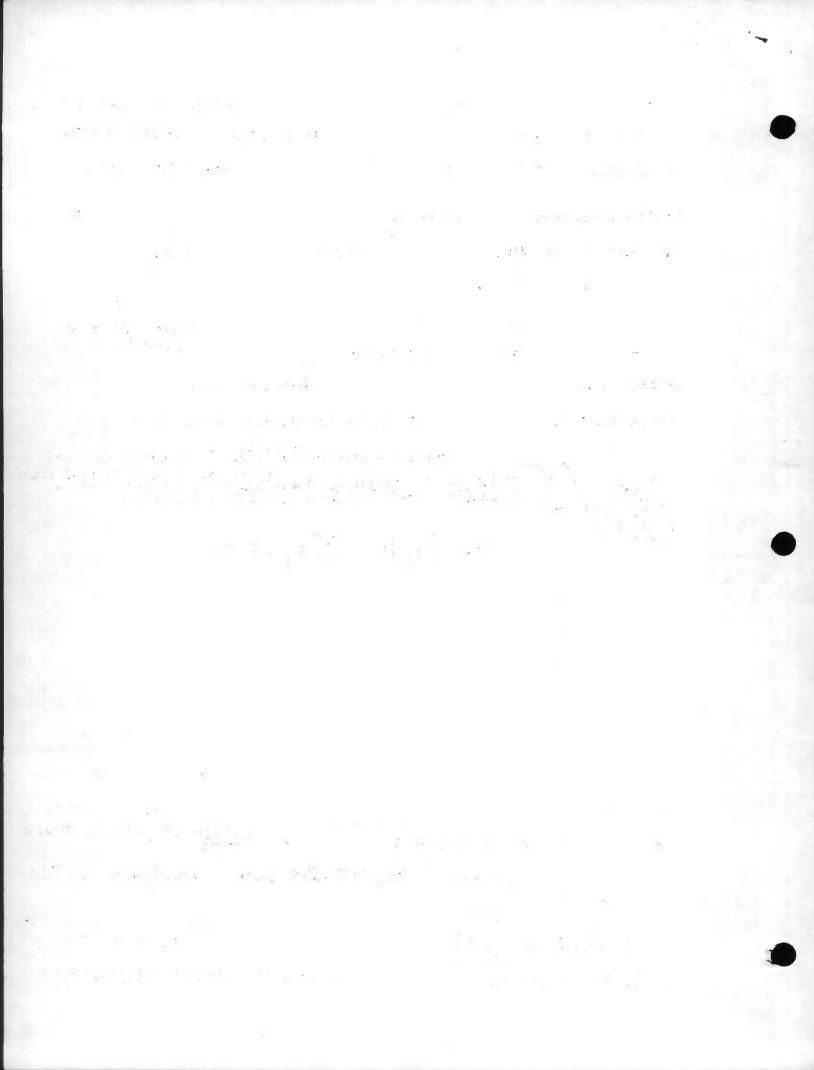
29d. Date signed (Month, Dey, Year) 11,1998 AUGUST

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Joseph Pestaner 1

111 Penn Street, Baltimore, Maryland 21201

32. Régistrer's Signeture



Division of Vital Records, P.O.

or Attending Physician: funeral within 24 hours efter de To the Funeral Directo completely filled in by th Hospital 2

State Registrar

Medicai

Natural

2 Accident 3 Suicide

4 Homicide

29b. Signature applie of certifier

29e. Certifier

5 Pending

investigation 6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

At home, farm, treet, factory, office

roods

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

1 Tyes

AUGUST 15, 1998

who completed ceuse of death (Item 23a) (Type, Print)

28e. Place of Injury - A building, etc. (Spe

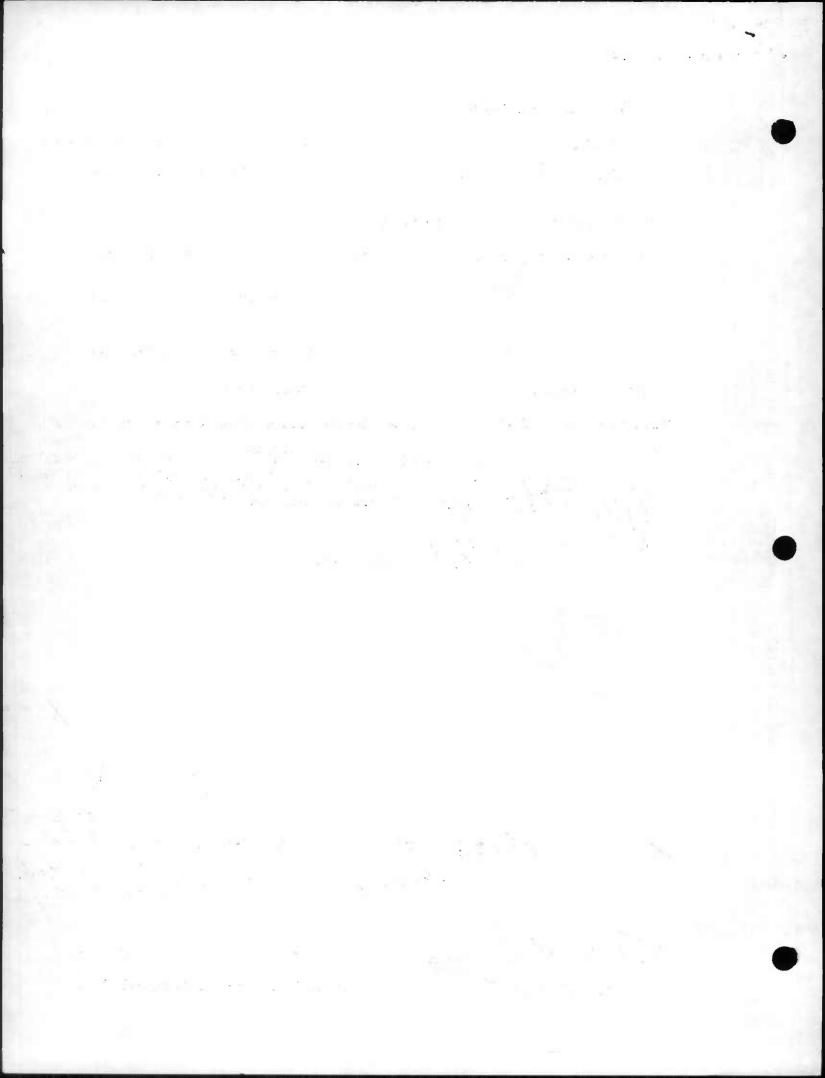
and manner stated.

111 Penn Street, Baltimore, Maryland 21201

end ves

Drive Mentgomeny Con

egistrar's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 8 26792

RUCKVILLE

RD.

				Certificate of Death								Reg. No.				
	Physicia		1. Decedent's Nam Cecelia	e (First, Middle, La	zafr	an	1	-			2. Dete of D August	2. Dete of Death .ugust 15, 1998 Year			3. Time of Death 1 pm	
10	/Medica Examine	_	4e Fecility Neme (	If not institution, gi	e street end n	um <i>ber)</i>				4b. City, Town,	or Location of Dea	th 4	c. County of	Deeth		
		J	Hebrew H	Home						Rockvil			Montgo	omery		
	Funeral Director		5. Social Security N 258-30-1	5680	Sex 1□M 252TF	Martha Davis Hause M					Hrs. 8. Date of B Min. (Month, D Sept.	irth Pay Yea 17,	<sup>7</sup> 1915	Birthpiac Country MA	ce (State or Fore	
	Aarylend I show	Usuel Residence of 10a. State VA	Decedent  10b. County  Fairfax	MILE	10c. C	ity, Town or Annai						10d. Inside City Lim 1X Yes 2 □				
	or 284-1 s								7. 0.1							
	) iter death with the reference 23s or 2 for must be a		3709 Wood		ıd			101.	Zip Code 22	003		USA				
1215-0020 within 72 hours effer death with the Marylend ene. than "naturel", or items 23s or 28s-1 show	ò	11. Maritel Status  1 Never Merried 2 Married  3 X Widowed 4 Divorced		Armed F	2 No	J,S. 1		cedent of pecify Cu 2 No.		? (Specify Yes or N uerto Rican, etc.)	0-	Black,	White, etc	0.		
5-0	Maryland 21215-0020 nd 2 should be filed within 72 hours eff th and Marnel Hyghen's File marked other than "natural", or traumatic event, the west and a factor To Be Completed by F	i ed	(Spec	15. Decedent's E	ducation	)	16e. De	cedent's U	suai Occ	upation	working	16b.	Kind of Busin	ness/Indu	stry	
2		ğ	Elementary/Seco		College (1-4or 5+)					e during most of red)	WOTALING	74				
2	DOL	5				5+	Libi	ania	n			acify Yes or No-Rican, etc.)  10g. Citizen of Whet Country?  USA  14. Raca - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry  Library  e (First, Middle, Maiden Sumeme)				
Pu	H lel H	P	17. Father's Name		)							e, Maide	n Sumeme)			
yla	should be ind Mentel merked o	0	William 1	Meltzer						Bess	ie Stone					
lar	2 4 5 5		19a. Informent's No							ete, Zip C	ode)					
2	CANL		Enid Zafi	ran-Daugh	ter					n Rd Ann	andale V					
Baltimore,	1022		20a. Method of Disp 1 Buriai 2 4 Donation	position ☑Cremation 3 [ 5 □ Other (Speci	Bemoval from	State	Placa of Dis cometery, c	remetory (	or other p							
Balti	permit. Pag Department Important: I any injury o 2009.		21 Signature of Fu	neral/Sevice Lice	yho .	0	/ 1	22. Name )anza	and Add	ress of Facility Goldber	g Memori	al (	Chapels	s, In		
	Physician /Medical Examiner  in-transit	Examiner	Immediate Cause disease or condition resulting in death)  Sequentially list confirm any, leading to interpretable to interpre		e. A.P. 10	YPER	CERE (or as a cons (or as e cons	1510	N	EP EPWE	WASCULA	r	pis	1	EARS	
0	certificate be nding physicle use as the bu	Medical	Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Disease or thet initiated events resulting in death)	injury S Lest	d	Due to (	or as e cons	equence	of):							
, P.O.	that the de ned by the detsched	by Physician	Pert II. Other signif					,							he cause of deal	
of Vital Records,	a law requir has been s ge 2 should	Completed b	DECUB	torosi itus l	ncei	R, K	PHE	erny	TOI	D AZT		formed?		comp of de	e autopsy finding able prior to pletion of cause eth?	
a		2	25. Was case refer	and to medical						00 Di			2LFN0		Tes 2LINO	
=	ystcien: s certific director.	ן מ	examiner?		Hospital:	)	750/0		201 0	ther .	Death (Check only		o 🗆 Out	(07.1		
on of	2 2 2	10n: 10	1 ☐ Yes 2 ☐ 27. Manner of Deet 1 ☐ Natural	h 5 Pending	28a. Date (Mo.		28b. Time Injur	of	28c. In	jury at ork?	28d. Describe					
≥	ofter death efter death Director: I in by the	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	e 28e. Plac	ea of Injury - At h ding, etc. (Spec			actory, office 28f, L			f. Location (Street and Number or Rural Route Number, City or Town, State)				
	Hospi 24 hou Funer stely fill	edical	29a. Certifier (Check only one)		niner: On the						laca, and due to the					
	within 2 To the comple		29b. Signature and	title of certifier	andille	100			29c. Lice	nse number	85		Date signed (			

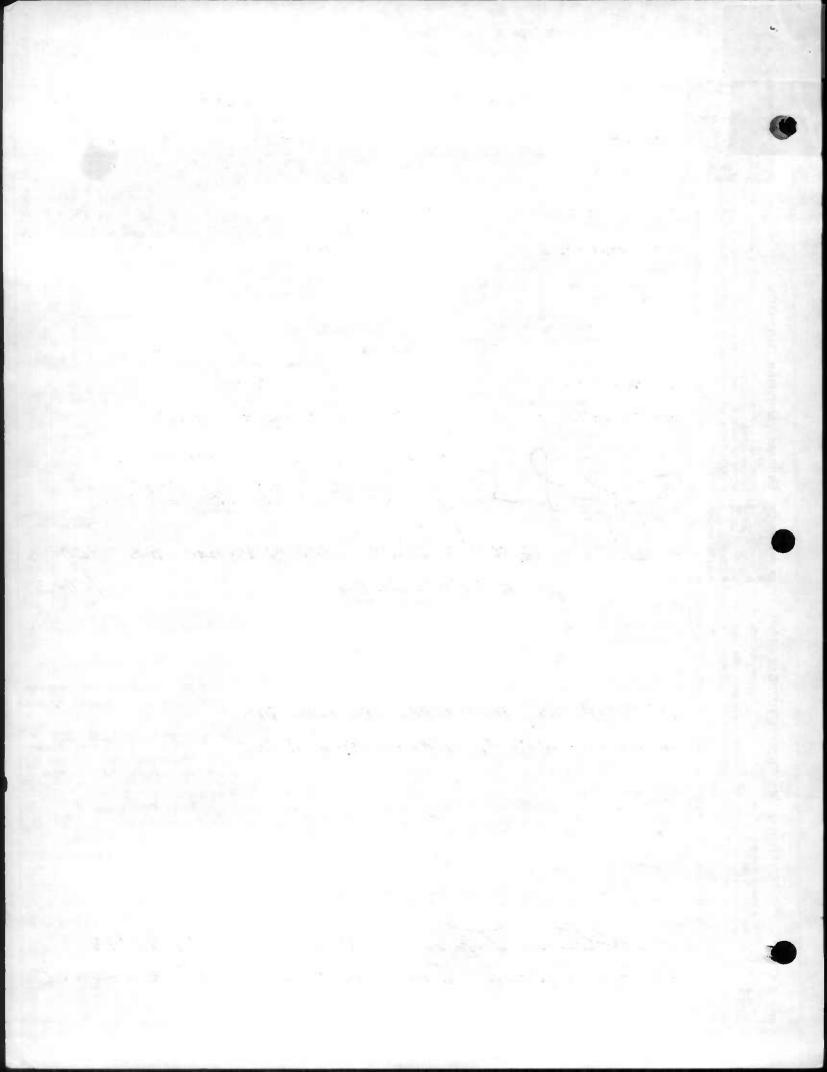
State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN LIPSON Col2/
31. Dete filed (Month, Day, Year)

AUG 19 1998

32. Registrar's Signature

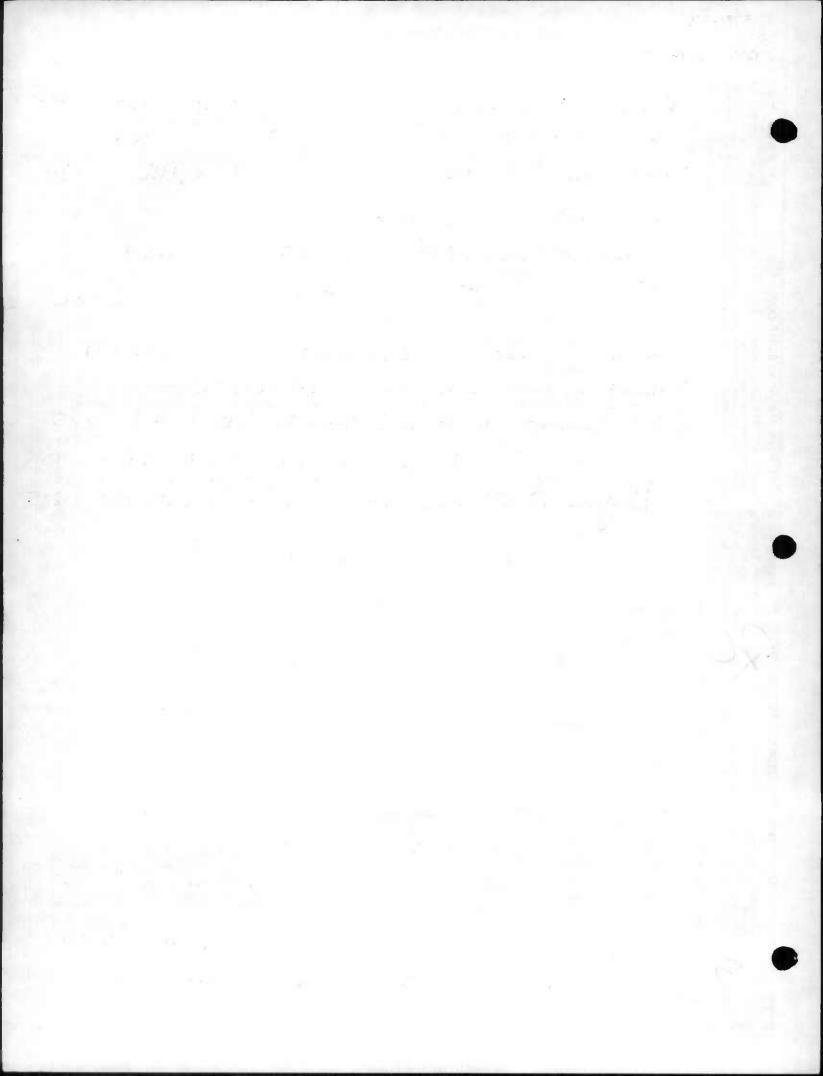
MONTROSE



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State of Maryland / Department of Health and Mental Hygiene) 8 26793

			Certi	ficate of Death	Reg	. No.	· , ,, -			
Ĭ	Physician /Medical	1. Decedent's Name (First, Middle, Last)  Robert AR	nstrona		2. Dete of Deeth Month AUGUST	Dey 28, 1998	3. Time of Deeth 0020 AM			
	Examiner	4e Fecility Neme (If not institution, give str 700 BLOCK OF CHER	eet end number)	4b. City, Town, or BALTIMO	Location of Death RE	4c. County of Death	h			
	Funeral Director	5. Social Security Number  2\3-02-09\(\rmathbb{e}\)2  Usual Residence of Decedent		f Under 1 Yeer If Under 24 Hr Honths Deys Hours Mir		9. Birti	hpleca (Stete or Foreign nuntry)			
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mantal Hyglane. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinet must be notified at To Be Completed by Funeral Director	10a. Stete 10b. County	10c. City, Town or Local  Balty				10d. Inside City Limits			
		10e. Street and Number 912 Beth	une Road	10f. Zip Code 21225	10g	Citizen of Whet Co	untry?			
020		3 ☐ Widowed 4 ☐ Divorcad	1 Yes 2 NAO	s Decedent of Hispenic Origin? (es, specify Cuben, Mexican, Puel Yes 2 10 Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Bleck, White Specify:				
0700-61717		15. Decedent's Educa (Specify only highest grede of Elementery/Secondary (0-12)	tion 16e. Deceder (Give kin life. DO	t's Usual Occupetion d of work done during most of with NOT use retired)  ODENT	orking 16	b. Kind of Business/				
ylaila		Robert LEE AC	emstrong Se	18. Mother's Na	me (First, Middle, Ma	++	Tin Code)			
		20e. Method of Disposition	20b. Pleca of proposition	Address (Street and Number or F	ol Balto	c. Location - City or	1552			
	permit, ragges Depertment of I Important: If Ite any injury or of once.	1 Suriel 2 Cremetion 3 Rer 4 Donetion 5 Other (Specify)  21. Sign was Funeral Service Licensee	LINA Me	molial tark ame end Address of Fecility arch funce	111	andalls? WESt:	Tuc.			
F	hysician /Medical	23a. Part Enter the a seese, or complication or heart at ure. List only one Immediate Ceuse (Finel disease or condition	tions that caused the death. Do not enter couse on each line.			satto mo	Approximete Intervel Between Onset end Death			
	Examiner	resulting in death)	Due to (or as e conseque			1				
	as the principal examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last  Due to (or es a consequence of):  Due to (or es e consequence of):								
	ad by the suprice deteched for use	d. Pert II. Other significent conditions contri	d							
, (50,000)	bed by				24a. Was en operforme	eutopsy 24b.	robably 4 ☐ Unknow  Were eutopsy findings eveileble prior to			
	Con Con				1/X Yes		completion of cause of death?			
	certificate rector, peg	25. Wes case referred to medical exeminer?			eath (Check only one)					
5	To To	XXYes 2□ No Hos	spital: 1 Inpatient 2 ER/Outpatient		Home 5 Residence		cify)			
TOISING.	deeth. ctor: Aftal y the fune	27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be determined	28e. Date of Injury (Month, Day Year)  8 4 9 9 28e. Pieca of Injury - At home, farm, street building, etc. (Specify)		28d. Describe how injury occurred  Subject was shot  281. Location (Straet end Number or Rural Route Number, City or Town, State) 700 BIK Cherry Hi  Baltimore City, Maryland					
	Funda Funda Icai	29a. Certifier (Check only one)  (Check only one)  (Check only one)	Street  lan: To the best of my knowledge, deeth or r: On the bests of examinetion end/or invested.	ccurred et the time, date end plet tigation, in my opinion, deeth occ	a, end due to the ceu	se(s) end menner es	s stated.			
,		29b. Signeture end title of cartifier  Atyp 1 A	Nacles, MP	29c. License number O.C.M.E.		I. Date signed (Mont AUGUST 28				
	5	30. Name and address of person who com	adentz 111 Penn	Street, Baltim	ore, Maryl	and 21201				
	State Registrar	31. Dete filed (Month, Day, Year) SEP 0 2 1998	32. Registrat's Signature	Sparks						



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State of Maryland / Department of Health and Mental Hygiene

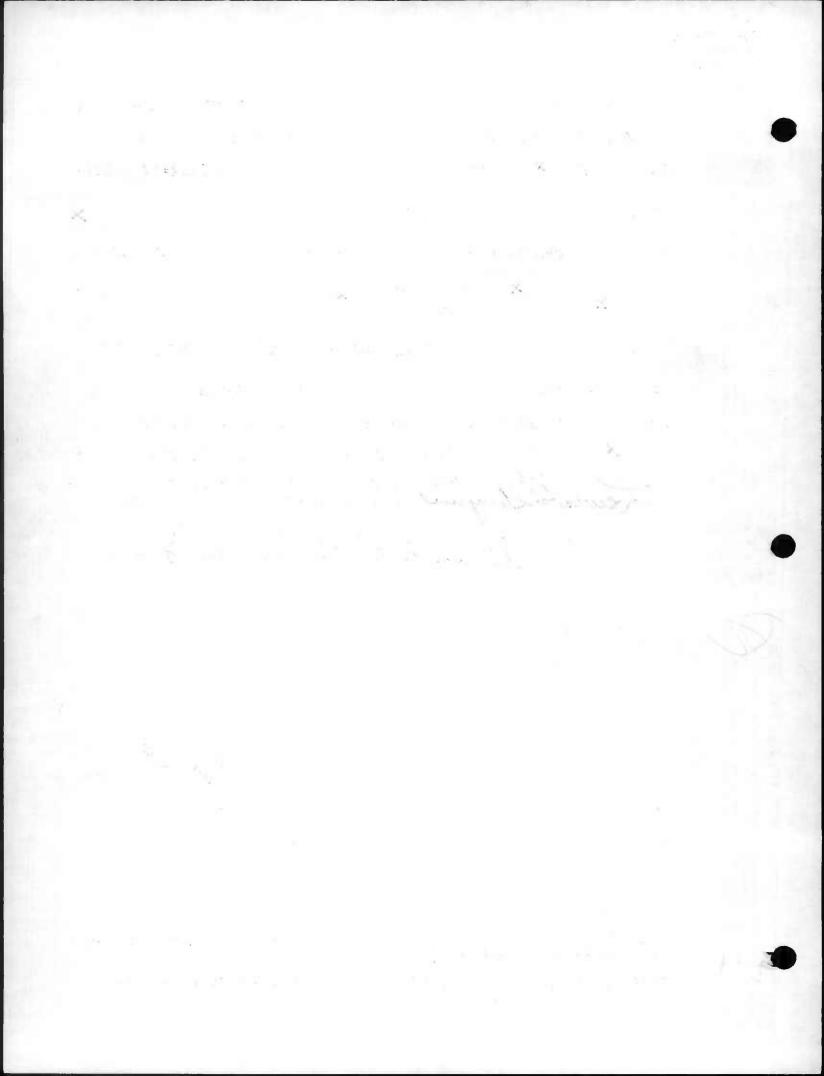
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BOARDLEY	and the state of		Cer	tificate of	Death		Reg. No.	60/94			
Physician	Decedent's Neme (First, Middle, Las     VERNON BOARDL					2. Date of De Month AUGUST	eth Dev Ye	3. Time of Death 5:59 PM.			
/Medical Examiner	4a Facility Neme (If not institution, give					or Location of Death	<u> </u>				
Funeral Director	213 20 0434	7. Age (In yrs	. lest birthday) Yrs.	If Under 1 Yeer Months Deys			9. 4,1929 M	Birthplace (Stete or Foreign County) ARYLAND			
e Maryland later show littled at	Usual Residence of Decedent  10e. State 10b. County 10c. N/A	10c. C	ity, Town or Loc BALTIN				10d. Inside City Lim				
od within 72 hours after death with the Maryland of within 72 hours after death with the Maryland Yajene.  We have "he hatural", or items 28 or 288-f show the the "helpe of 288-f show the the "helpe of 288-f show the most be notified at the Completed by Funeral Director.	10e. Street and Number 3628 OLD FRERE	RICK ROAD	10f. Zip Code 212	29		U.S. O					
	3 ☐ Widowed 4 Divorced	12. Wes Decedent Ever In L Armed Forces? 1 Yes 2 Ng 1 / If Yes, Give 1 / Yeer or Detes 8 / 2.8	1 Yes 2 Ng 1 / 29 / 50			(Specify Yes or No erto Rican, etc.)	Bleck, V	Americen Indien, Vhite, etc. BLACK			
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be file	17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)										
or other	19a. Informant's Neme/Relationship (7, DONNA FINCH (D. 20a. Method of Disposition 1 Burial 2 Cremetion 3 1 4 Donetion 5 Other (Specify,	AUGHTER)  20b. Removel from State	1356 Place of Disposementery, crem	PENTRI sition (Name of patory or other pla	DGE RO	AD BAL					
Physician /Medical Examiner	21. Signature of Fuorm Service Licent 23a. Pert1. Enter the disease, or comp shock, or heert feilure. List only of Immediate Cause (Finel disease or condition resulting In death)	lications that my bd the dearne couse on each line.	V 45	517 PAR or the mode of dy	K HEIG	FUNERAL HTS AVE diac or respiratory e	. BALTO	21215-6393 , , MD.  Approximete Intervel Between Onset end Death			
carrings be executed notice of the control of the c	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Undertying Cause (Diseese or injury that initiated events resulting in deeth) Lest	c	or es e consequence as e consequence								
as that the daath ca igned by the attendi be datached for use by Physician/I		ntributing to death but not re	nderlying ceuse g		23b. Did tobacco use contribute to the cause of death						
The lew requir ate has been s page 2 should Completed						Perfe	an autopsy primed?  Yes 2 \( \sum \color \co	4b. Were eutopsy findings aveilable prior to completion of cause of deeth?  1 Yes 2□ No			
Physician: The Physician: The contificate rai director, page TO Be CO	25. Wes case referred to medical examiner?	Hospitel:		- 0	her:	Deeth (Check only					
- 5 S D	1 X Yes 2 No 27. Manner of Deeth	1 ☐ Inpatient 2 ☐	28b. Time of	1 3LI DUA	4 LI NUISIN		dence 6 Other (	Specify)			
bal or Attending P is after death. In Director: After the darin by the funers Certification:	1 Haturel 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be 4 Homicide determined	(Month, Dey Year)  28e. Plece of Injury - At I	Injury		Yes 2□No		28d. Describe how Injury occurred  28f. Location (Street and Number or Rural Route Number,				
Hospi 4 hou Funer taly fill		building, etc. (Special sician: To the best of my kniner: On the bests of examin	owledge, deeth			ece, end due to the	cause(s) and manne				
To the tail within 2.	29b. Signeture end title of certifier	end manner stated.	0	29c. Licen	se number		29d. Dete signed (N AUGUST 27	fonth, Dey, Year)			
5+1	30. Neme and address of person who co	1.0	m 23e) (Type, l .11 Penr		, Baltin	nore, Mary	yland 2120	01			

State Registrar

31. Dete filed (Month, Day, Year)

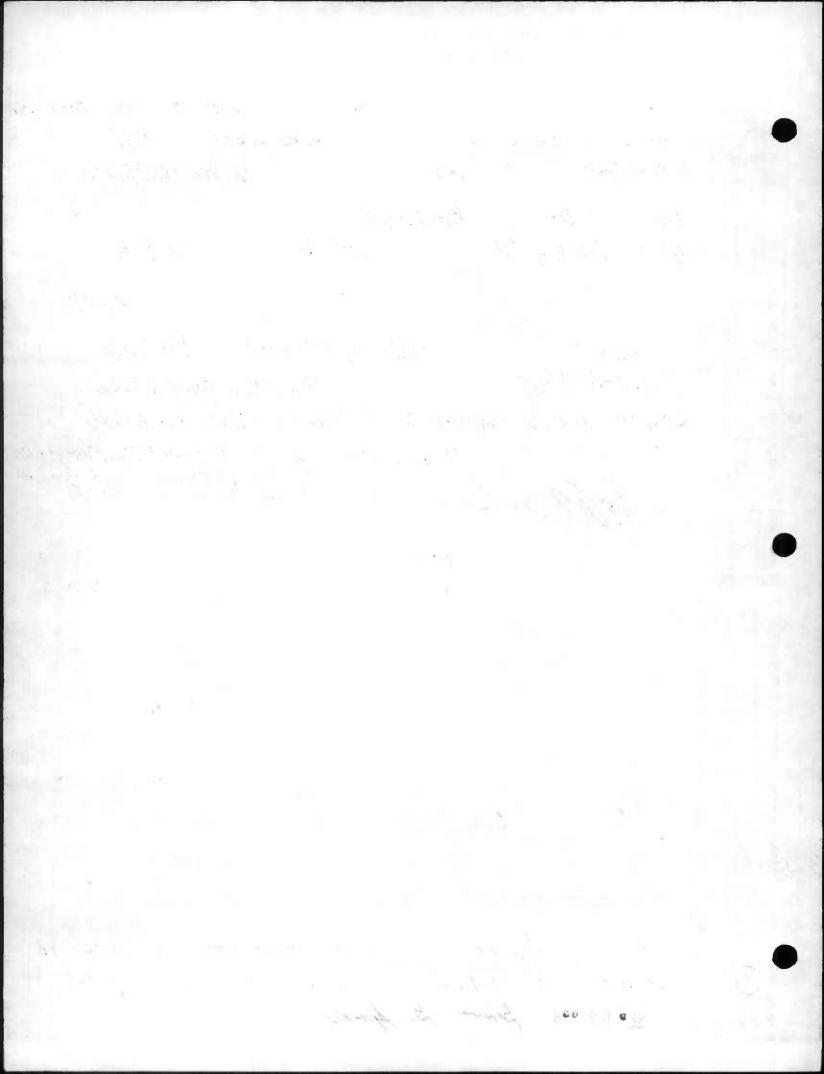
32 Aegistrer's Signeture



Amend: #29c Per Field Rep-DB Film G763 9State of Maryland / Department of Health and Mental Hygiene Cartificate of Death Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 22, 1998 10:30 a.m. BREHON DENETA /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner 9. Birthplace (Stata or Foreign THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY 5, Social Security Number 220-88-3438 7. Age (In yrs. last birthday)
Yrs. If Under 1 Yeer | If Under 24 Hrs. 1 M 2 F Months Deys Hours Director Usual Residance of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frama 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10e. Street and Numbe 10g. Citizen of What Country? 22 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23. 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 W Married 1□ Yes 2♥No Black Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade complated) 16e. Decedant's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use ratired) Elementary/Secondery (0-12) College (1-4or 5+) Mother's Name (First, Middle, Majden Sumame) 17 Father's Name (First, Middle, Last 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, State, Zip Code) 22 other t altimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removel from State eny injury or 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility GARY P. 270 FREDHILTON PASS BALTO, MS 2122 e, or companions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Approximete Interval Between Onset and Daath **Physician** /Medical Immediate Lausa (Final disease of condition resulting in daeth) 24 hours SEPSIS Examiner Dua to (or as a consequence of): Examiner 5 YEARS HIV hysician and the burial-transit Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in deeth) Lest Due to (or es a consequence of) certificate be exec Box 68760. physician Physician/Medicai Due to (or es e consequence of) 88 use a 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by 1 Yes 2 No 3 Probably 4 Unknown by Division of Vital Records. 24e. Was en eutopsy performed? 24b. Were eutopsy findings available prior to Completed completion of causa of death? page 2 Aftar this certificata has 1 Yas 2 No 1 ☐ Yes 2 6 No 25. Was case referred to medical examiner? Be 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) funeral 28d. Describe how Injury occurred 27. Mannar of Death 28b. Time of 28c. Injury et Work? Certification: or Attending 5 Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death. To the Funerei Director: Af 1 Yes 2 No 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier 1🕱 Certifying Physicien: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as stated. Medicai completaly 2 Medical Exeminer: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29c. License number P11668 29b. Signature end title of certified 29d. Dete signed (Month, Day, Year) dans 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) ani 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

Piease Type or Print in Black Indelible ink. Assure All Copies Are Legible.



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey -AT 1998 EARL SEPTEMBER IST 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not Institution, give street end number) NORTHWEST MEDICAL CENTER RANDALLSTOWN BALTO. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 12 M 2□ F Months Deys Hours Min Yrs. 4/4/11 VIRGINIA 213-03-8605 Usuai Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE RANDALLSTOWN 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8538 STEVENSWOOD ROAD U.S. 14. Rece - American Indien, 21244 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced BLACK 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) -0-CLERK STATE 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) CALVIN BALL JOSEPHINE (UNKNOWN) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) ROSALIND DAVIS (DAUGHTER) 8538 STEVENSWOOD ROAD-RANDALLSTOWN, MD 21244 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriei 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) CEDAR HILL CEMETERY 9/4/98 GLEN BURNIE, MARYLAND 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility ELIZABETH L. PHILLIPS, P.A. 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 n erecka 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximete Intervei Between Onset end Death Immediate Ceuse (Fine) UROSEPSIS diseese or condition resulting in death) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL FAILURE 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Wes en eutopsy DIABETES MELLITUS 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death

**Physician** /Medical Examine

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland Hygiene. Hysiene "natural", or Items 23a or 28e-f show ent, its Medical Experience must be notified at

. Pages 1 and 2 should be file ment of Health and Mental Hy lant: If item 27 is marked oth jury or other traumatic event

permit. Page Department important: If any Injury or

Baltimore, Maryland 21215-0020

Examiner Physician/Medical à 80 Completed

certificate has inector, page 2: after deaf Director:

Be

2

Certification:

edical

1 Neturel

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Division of Vital Records, P.O.

To the To To the To the I

Hospital 24 hours a

25

28b. Time of 28a. Dete of Injury (Month, Dey Yeer) investigation

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred 28c. Injury et Work? 1 ☐ Yes 2 ☐ No 281. Location (Street end Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. (Check only one) 29b. Signeture end title of certifier mehla mo

29c. License number

29d. Date signed (Month, Dey, Year) September 157, 1998.

30. Name end eddress of person who completed cause of death (item 23e) (Type, Print)

21133 NORTHWEST HOSPITAL CENTER RANDAUSTUMN MO LOGINGER PMEHTA 31. Dete filed (Month, Day, Yeer)

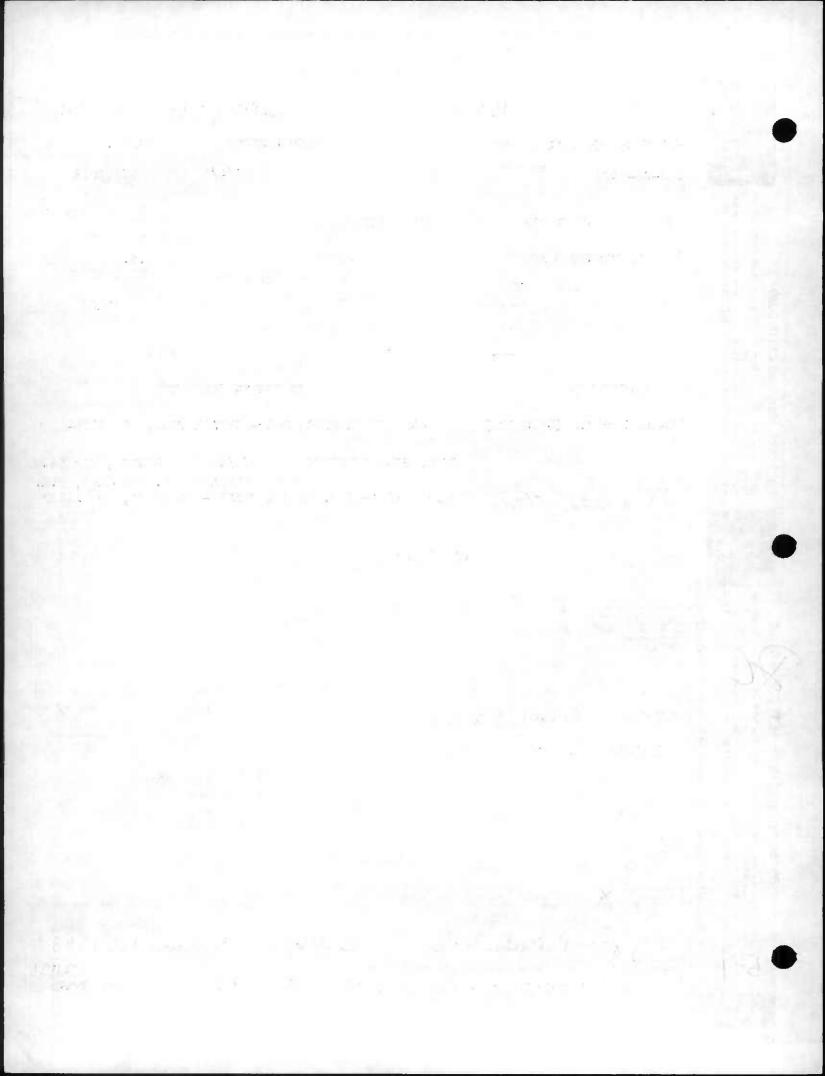
State Registrar

5 Pending

6 Could not be determined

32. Registrer's Signature

**DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5:40 AM 8 James 98 27 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10 Greene Street Baltimore Bultimore VAMC 5. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplace (Stete or Foreign Country) 1₽M 2□F 245-26-5040 Yrs. Director Usuel Residence of Decadent with the Manyland permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any Injury or other traumatic event, the Madral Examples motified at page. 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA TO YOS 2 No BaHimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21239 U.S. A 1324 Silverthorne 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 1 Thes 2 □ No If Yes, Give Year or Detas: 1 Never Married 2 Married Black 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuef Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Baston Metal Elementary/Secondary (0-12) Collaga (1-4or 5+) machinist 12th grade 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Berry maude Valentine Walter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1324 Silverthorne Rd, BattanD Berry Virginia 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removal from State 9-1-98 Caurel, MD Not. MEM 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility 1101 E. North the EAST Fitt March 23 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Intervel Batwaan Onsat end Deeth Physician /Medical Immediata Causa (Final diseese or condition resulting in death) MaligweenT hour **Examiner** Physician/Medical Examine Apritic Due to (or es e consaquence of) Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown Hypercholesterolemia 24b. Were eutopsy findings eveilable prior to complation of cause of daeth? 24e. Wes en eutopsy performed? Completed r this certificate h 1 Yes 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Daeth (Check only one) Othar: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2□ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No Director: A in by the fi 2 ☐ Accident 6 Could not be datermined n 24 hours efter der ne Funeral Directo pletely filled in by th 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 4 ☐ Homicida 29e. Cartifian Medical 1 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, date end place, end due to the ceuse(s) and mannar as stated. (Check only one) 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the cause(s) end manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier Resident 30. Name end eddress of person who complated causa of deeth (Itam 23a) (Type, Print) South Greene, Paltimore MD21201

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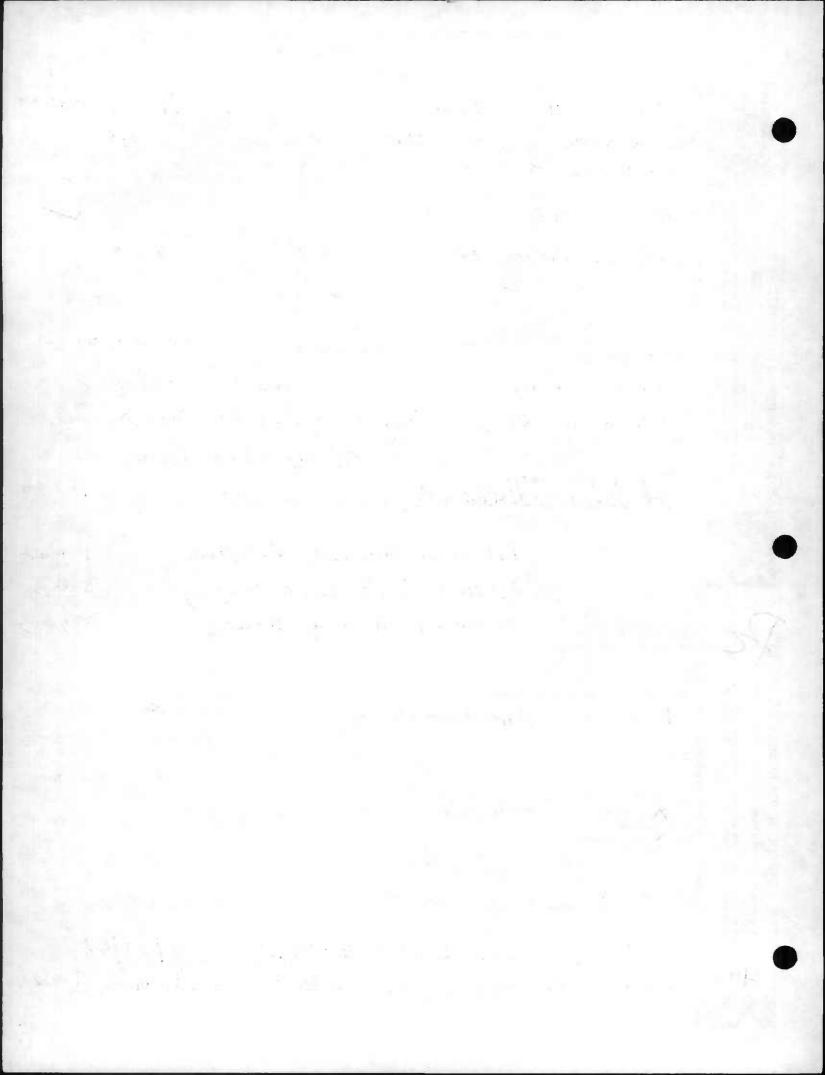
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32 Registrar's Signatura

Registrar

Charles S.

31. Deta filed (Month, Day, Year) SEP 0 2 1998



## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

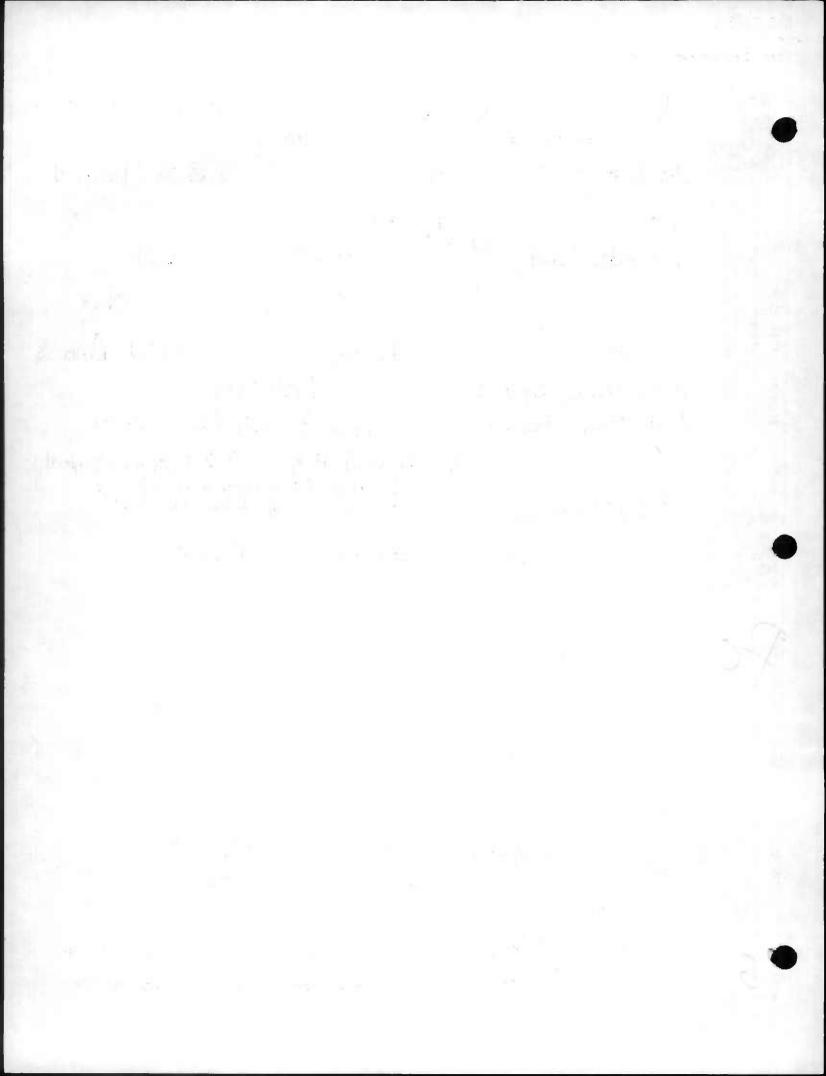
State of Maryland / Department of Health and Mental Hygiene

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Sparker

State Registrar

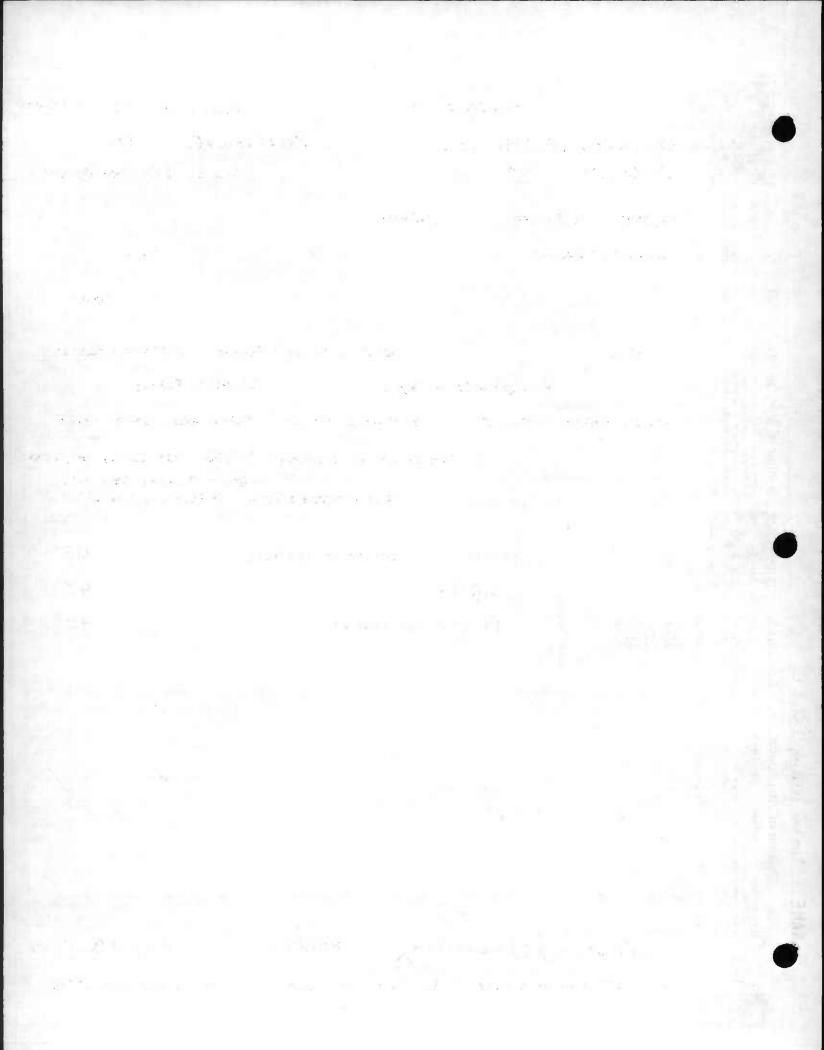
DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Dev **Physician** 8:05 AM Rose Grace Beyer August 1998 30 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner St. Agnes
5. Sociel Security Number BOUT I MOVE Care N/A Health If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Funeral Months 1 M 2 X F Days Hours Yrs. 208 40 5137 93 31, 1904 New Jersey **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimore Baltimore Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with r than "natural", or items 23s or the Medical Examiner must be r U.S. 4100 Maple Avenue 21227 Funeral death 14. Rece - American Indian. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 CNever Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Services / Prayer Religious Sister 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Catherine Reilly Rudolph William Beyer 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 4100 Maple Avenue Sr. M. Pauline Bilbrough Baltimore, Maryland 21227 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 XBuriel 2 Cremation 3 Removal from State 9/2/98 Baltimore, Maryland New Cathedral Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signajure of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. rameroush 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or com-shock, or heart failure. List tions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, cause on each line. Approximate tnterval Between Onset end Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) Multiorgan system failure /Medical Examiner Due to (or es e consequence of): Sepsis edibal Examin Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Perforated colon Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): Physician/M 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown à 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy parformed? Completed 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 1☐ Yes 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. tnjury et Work? Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 29a. Certifier 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigation, In my opinion, death occurred at the time, date end placa, end due to the cause(s) end manner stated. 24 To the Within 2 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signeture and title of cartifier Musten 30. Name and address of parson who completed cause of deeth (Item 23e) (Type, Print) Dr. Kristin L. Fernandez 900 S. Caton Avenue Baltimore, Maryland 21229 6°2°1998 32. Registrar's Signature Registrar

Inster May Beyor



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State of Maryland / Department of Health and Mental Hygiene Amend: #14 Per FH Film G763 9-3-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** Helen V. Copeland / Downing September 01, 1998 2:33pm/Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Good Samaritan Hospital N/A Baltimore 8. Date of Birth (Month, Day, Year) December 23,1923 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Davs 1 ☐ M 280 X Houra Yrs 215-40-1347 Director 74 VA Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits id 2 should be filed within 72 hours efter deeth with the Merylan the and Mental Hygiene.
It is marked other than "natural", or items 23a or 28a-f show traumatic event, its Medical Examine must be notified as MD N/A Baltimore City 1 XX es 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2143 Homewood Avenue 21218 United States Funeral 11. Maritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black. White, etc. 1 Yes 2000 to If Yes, Give Yeer or Detes: 1 Never Married XX Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade N/A Cosmetologist Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas T. Copeland, Sr. Nellie Slight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 Department of Health e Important: If Item 27 la any injury or other trai Thomas G. Downing / Husband 2143 Homewood Avenue, Baltimore Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Greenlawn Memorial Gardens Sept. 5, 1998 Chesapeake, VA 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. Servi 1501 East Fort Avenue, Baltimore, Maryland 21230 23a. Part1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 2 Weeks Sepsis Examiner Due to (or as a consequence of) Examiner 2 Years Renal Failure Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Diabetes Mellitus 68760 Physician/Medical Due to (or es e consequenca of) Box 080 for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 6 1 Yes 2 No 3 Probably 4 Unknown Cerebrovascular Accident signed t Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Ischemic Heart Disease hes 1 ☐ Yes 20tNo 1 ☐ Yes 2 ☑ No certificate Division of Vital funerel director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2000 15 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending investigation **PONatural** deeth. 1 Yes 2 No after deeth Director: A 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a Funeral D edicai 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. To the Hosp within 24 ho To the Fune complately fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D 46907 September 1, 1998 30. Name and addr who completed cause of death (Item 23a) (Type, Print) Hyung 5601 Loch Raven Blvd, Baltimore Maryland 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 2 1998 Seper Registrar

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Attending or death.	atio	1 Avaturel 5 ☐ Pending investigation	(WORTH, Day 1621)	Injury M	1 Yes 2 No							
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2		30. Name end eddress of person who con	npleted compared deeth (Ite	m 23a) (Type, Print)	. 11 5			30,1998 450, MP, 21202				
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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** DESPER 12:4C /Medical 4b. City, Town, or Location of Deet 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Liberty Medical Center 5. Social Security Number 6. Sex 7. Ana Baltimore If Under 24 Hrs Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Deys 10 M 20 F Months 240-48-9571 Usuel Residence of Decedent 61 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Baltimore MD NA 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21215 Funeral 3503 Lucille Ave 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Yeer or Detes: Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Laborer 4th grade 17. Fether's Name (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Surname) Be P Vence Lawson George Clayton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Ellen Clayton-Wife 20a Method of Disposition 21215 3503 Lucille Ave, Baltimore Md 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 8/27/98 Randallstown, Md 4 Donation 5 Other (Specify) King Memorial Park ture of Paneral Service Lid 22. Name end Address of Facility March F/H West 4300 Wabash Ave, Baltim how, or heart failure. List crity one cause on each line. Baltimore, Md 21215 Approximate Intervel Between Onset end Death TIBRILLATION Immediate Ceuse (Finel disease or condition resulting in death) ertension Physician/Medical Examine Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of) that initieted events Due to (or es e consequence of): resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to 24a. Was en eutopsy performed? Completed comptetion of cause of death? 2 XNO 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No

Division of Vital Records, P.O. The law has page 2 certificate. Physician: 皇 after death.
I Director: After d in by the funer To the Hospital within 24 hours a To the Funeral Completely filled

**Funeral** 

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, the Medical Examinating the notified at

permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy; Important: If Item 27 is marked othe any injury or other traumatic event, DDGs.

**Physician** 

/Medical

Examiner

Saltimore, Maryland 21215-0020

investigation 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier

3 Sulcide

4 Homicide

\*\*Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and menner stated.

29b. Signeture end title of

29c. License number

21215

29d. Date signed (Month, Day, Yeer)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Liberty Height Ave, Baltimore Maryland 2600

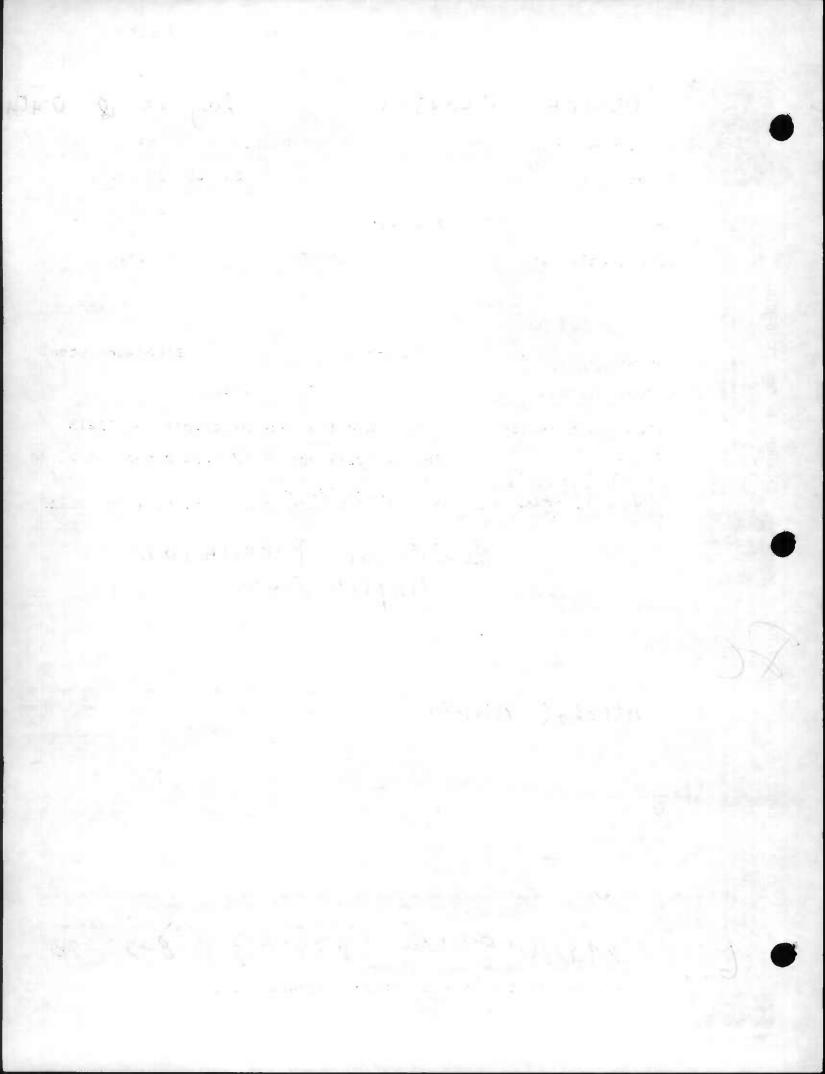
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31. Date filed (Month, Day, Year) SEP 0 2 1998

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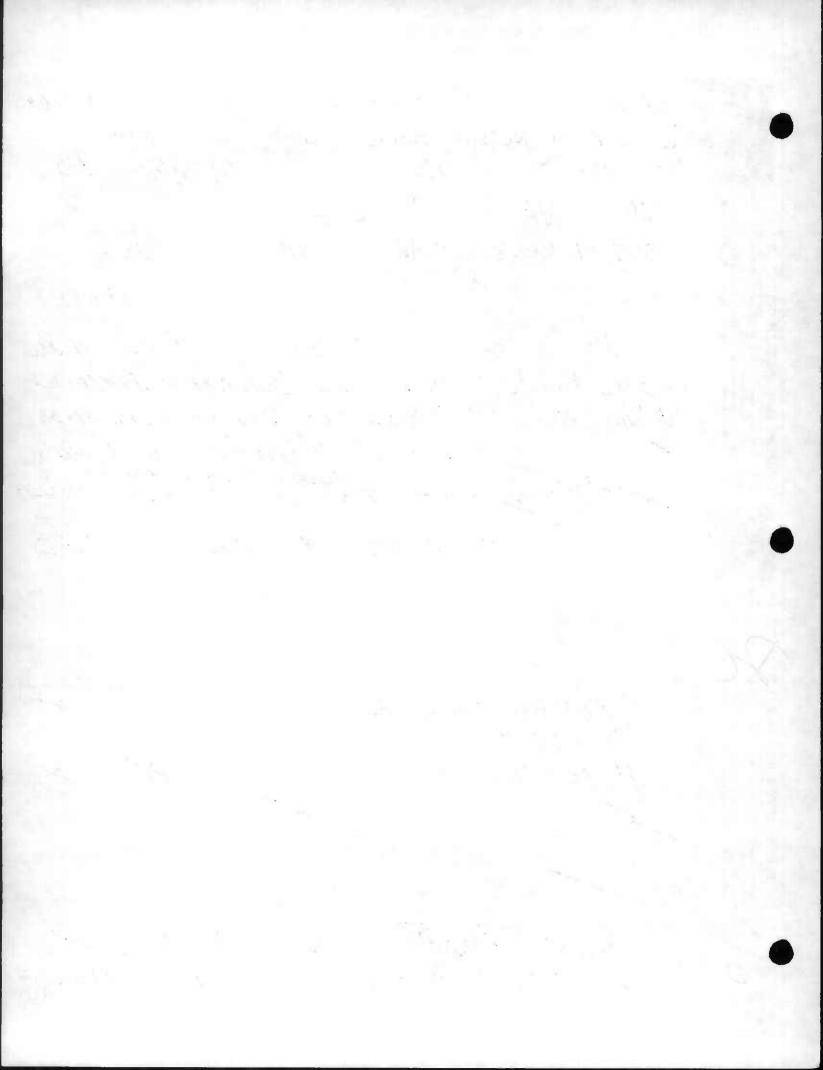


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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0:10 A.M Jerome mmodore 30 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Baltimore SING If Under 24 Hrs. 5. Social Security Number 7. Age (fryrs. last birthday) 8. 9. Birthplace (State or Foreign Country) **Funeral** 218-18-207 Months Days NOM 20 F Director Usuai Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or thems 23s or 28s-f shot traumstic event, the Medical Examines must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2525 21215 LVEDERE Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S.
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If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 by 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Uaual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Induatry College (1-4or 5+) Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be filt innent of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be ILIZA BETH FARREL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEP-SON William Andallston, 40 21133 20b. Place of Disposition (Name of cometery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department c Important: If any Injury or 21. Signature of Funeral Service Licenses will MORE, NO2/2/7 8 N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest abock, or heart failure. List only one cause on each line. Approximate Interval Between Onaet and Death **Physician** Immediate Cause (Final disease or condition reaulting in death) CANICER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. à 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findinga available prior to completion of cause of death? 24a. Waa an autopsy performed? Completed 1 ☐ Yes 2 No 25. Was case referred examiner? Be 28. Piace of Death (Check only one) 20100 Hospital: Other Lo ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Athor this 28a. Date of Injury (Month, Day Year) 28d. Deacribe how injury occurred 28b. Time of Injury 28c. Injury a Work? 27. Munner of Death Certification: Natural 2 Accident 5 Pending investigation 2 No 1 Yes after death Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 4 Homicide 6 24 hours edical 29a. Certifler Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. To the within 2 To the 29b. Signature and title of certifier 29d. Date sign#d (Month, Day, Year) 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) \_0 31. Date filed (Month, Day, Year) SEP 0 2 1998 32/ Registrar'a Signature State Registrar

**DHMH 16 Rev 6/95** 



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg. No. 1. Decedent's Neme (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month NICHOLAS LOUIS 4b. City, Town, or Location of Deeth CRANE 30 1998 4c. County of Deeth 5:50 AM 4e Fecility Neme (If not institution, give street end number) Saint Joseph Medical Center Towson Baltimore If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5-28-1924 6. Sex 7. Aga (In yrs, last birthday) Birthplace (Stata or Foreign Country) Months Days Hours XXM 2DF 74 Yrs. 212-20-4918 Maryland Usual Residence of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 Yes 2X No Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 8810 Ashford Road U. S. A. 21234 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puerto Ricen, atc.) 11. Marital Status 1 Yes 2 No If Yas, Giva Yeer or Dates: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) BGSE Computer Analyst 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Louis Crane Deonecia Calogredia 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Mrs Carolyn A. Crane (Wife) 8810 Ashford Road, Baltimore, Maryland 21234 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date Greek Orthodox Cemetery 14 Burial 2 Cremetion 3 Ramoval from Stafa 9-1-98 Woodlawn , Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensea 22. Nema and Address of Facility 1050 York Road Wallace Ruck Towson Funeral Home, Inc. 2 S Towson, Md. 21204 23a. Pent1. Enter the disease, or complications that causad the death. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximeta Interval Between Onset and Death Immediata Causa (Final CARDIAC ARREST 30 MIN disaasa or condition rasulting in daath) Dua to (or as a consequance of): ARTERIOSCLEROTIC CORONARY ARTERY DISEASE 14 YEARS Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy tindings evailable prior to completion of ceuse of death? 24a. Wes an autopsy 1 Yas 2 No 1 Yas 2 No

**Physician** /Medical Examiner

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certificete Physician:

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at

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permit. Pages 1 and 2 should be filed will Department of Health end Mental Hygiens Important: if fam 27 is marked other tha any Injury or other traumatic event, that page.

Director

Funeral

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Baltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

Examiner Sequentially list conditions, if eny, leading to immadiata ceusa. Entar Undarlying Cause (Diseasa or Injury that initieled events rasulting in death) Last and Physician/Medical physicia for use as the signed by

Part If. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. RENAL INSUFFICIENCY à Completed 25. Was cesa refarred to medicel axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 9 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Deta of fnjury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Tima of 28c. fnjury at Work? Certification: 1 Netural
2 Accidant 5 Panding invastigation 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

4 Homicide 29a. Cartifian (Check only one)

10 Certifying Physician: To tha best of my knowledga, death occurred at tha time, dete and place, and dua to the causa(s) end manner es steted.
2 Medicel Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, end dua to the cause(s) end manner stated.

29b. Signature and title of pertities

29c. Licansa number 29d. Deta signed (Month, Day, Year)

D38655

30. Nama end addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)

R.C. STEWART FINNEY, 7505 OSLER DRIVE. M. D. TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

Registrar

Medicai

SEP 0 2 1998

32. Regisfrer's Signature

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ician dical	1. Decedent's Name (Firs													
	JOSEPH		ERVIN	J	DAV	15				2. Date of Dec Month AUG.	Day 25, 199	Year 8		of Death
niner	4a Facility Name (If not in (CORNFIEI						4	4b. City, Too HANC		cation of Deeth		y of Death E ARUI	NDEL	1
al or	5. Social Security Number 249-28-00	001	Sex 1⊈M 2□F	7. Age (In yrs	s. lest birthda Yrs.	Months	Year Days	if Under: Hours	Min.	8. Date of Bird (Month, De MAY		Count	try)	ROCIN
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To	20E			DAVIS					LA		WIL			
	19e. Informant's Name/R					ailing Address (								0
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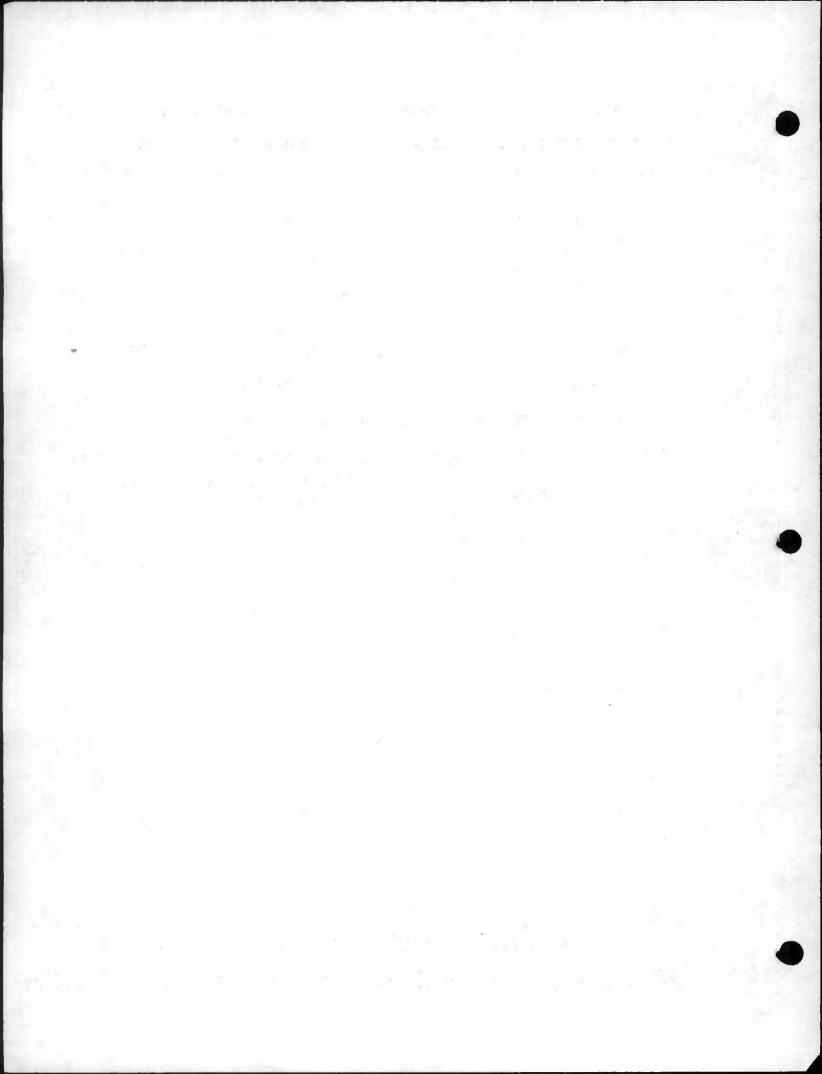
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State of Maryland / Department of Health and Mental Hygiene 0 0

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and		10e. Stete 10b. County 10c. City, Town or Location										10d. Inside Ci	tv Limit		
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To th within To th comp		29b. Signature end title of certifier	Lan	1	UQ	290	Licens	25-30	91	2	9d. Dete sign	ed (Month,	Dey, Year)		
6		30. Name and eddress of person who completed cause of death (Item 23e), (Type, Print)  Rhan, 5601-Loch Raven Blvd, Balko Mis										to me	2, 2		
Stat Registra		31. Dete filed (Month, Dey, Year)		rar's Signature	2		10						21	25	

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey 30 1998 4c. County of Deeth 4b. City, Town, or Location of Death Edward Albert DeVille, Sr. 10:45 AM 4e Facility Name (If not Institution, give street and number) Manor Care Towson Towson If Under 24 Hrs. Hours Min. Baltimore Co. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar Birthpleca (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) 6. Sex Months 1 M 2□ F Deys 82 215-14-5736 Feb.02.1916 Iowa 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐No Maryland Baltimore Co. Sparks 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 16309 Yeoho Road 21152 United States 12. Was Decedent Ever in U,S. Armed Forces? ¹\%\Yes 2 □ No If Yes, Give Yaer or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11. Marital Status Bleck, White, atc. 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Artist Paintings 12 06 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward J. DeVille Inez M. Davis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 16309 Yeoho Road Mr. Eric A. DeVille (Son) Sparks, Maryland 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Hilltop Service Corp. 9/02/98 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service Licensee Jeffrey L. Gair 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, only one causelon each line. Approximete Intervel Between Onset end Deeth tmmediete Ceuse (Finet disease or condition resulting in deeth) Due to (or es e consequence of) Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown larlure

**Physician** /Medical **Examiner** 

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The law requires that the death certificate begrecuted

Box 68760,

Records,

Division of Vital

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Physician/Medical Examiner

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any injury or other traumatic event, Ital

**Physician** 

/Medical

**Examiner** 

10e. State

**Funeral** 

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r than "natural", or items 23a or 28a-f show

death

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Maryland 21215-0020

Baltimore,

Directo

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Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted avents resulting In death) Lest

30. Name end eddress of person who completed cause of deeth (Hqm 23a) (Type, Print)

24a. Was en eutopsy performed?

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth?

26. Plece of Death (Check only one)

1 ☐ Yes 2 ☐ No

25.	exeminer?	
22	Manney of Death	

5 Pending investigation

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28b. Time of Injury

28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

3□ DOA 28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Yes 2 LN

28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a	Certifiar
	(Check only
	( Other oth)

1 Naturet

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted.

29c. License number

29b. Signature end title of certifier

net

1 ☐ Yes 2 ☐ No

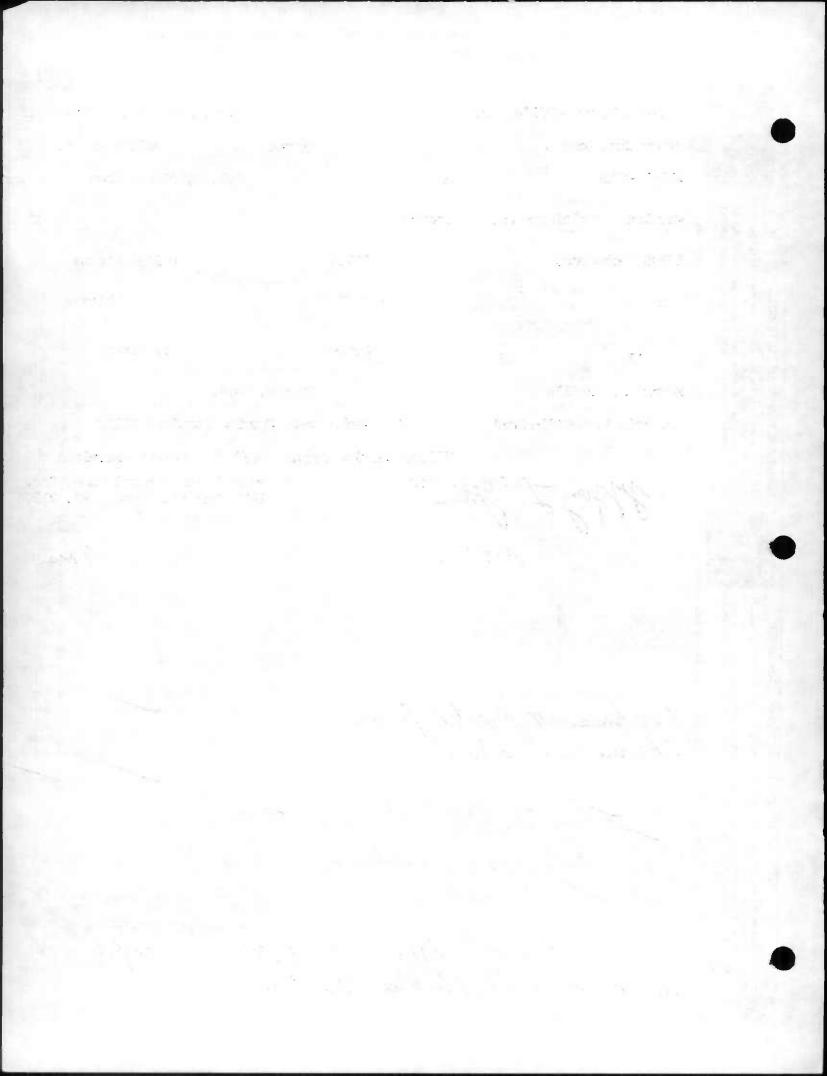
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To the Funeral C

Carm 31. Dete fited (Month, Day, Year) State 0 2 1998 Registra

d arkton 32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #26 Per MD Film G763 9-2-98RC Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** 12, 1998 Thomas Edward Elkins, MD 0126 August /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Baltimore
If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dey, Yeer) Greater Baltimore Medical Center Baltimore 5. Sociel Security Number 6. Sex 11 M 2 □ F If Under 1 Yeer Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** Months Deys Director 450-86-7131 48 23, 1949 Texas Usual Residence of Decedent the Maryland 10d. Inside City Limits t than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 1 Yes 2 No Director Baltimore Cockeysville 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code TISA Funeral 20 Valley Crossing Circle 21030 death 14. Rece - American Indien, Black, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status filed within 72 hours effer a Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: White 2 3 Widowed 4 Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) 12 5+ Physician Medicine in marked other permit. Pages 1 and 2 should be file Department of Health and Mantal Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, page. 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Novis Noble Elkins Kathryn Ellison Laura 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20 Valley Crossing Circle Cockeysville, MD 21030 Carolyn E. Elkins/Wife 20b. Pleca of Disposition (Neme of cemetery, crematory or other plece) Aug. 18, 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sea Side Memorial Park 1998 Corpos Christi, TX 22. Name and Address of Fecility 21. Signature of Funeral Service Licansee Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, Maryland 21093 a Clary 23a. Part1. Enter the mode of dying, such es cardiac or respiretory errest, shock, or heary failure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** hac orrhything /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequenca of): Physician/Medical Due to (or es e consequenca of): usa as signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Records, þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was en eutopsy Completed hes 1 Yes 2 □ No 1 Yes 2□ No certificate Division of Vital funeral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 nesidence 6 Other (Specify) DOA 2 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 1 Natural 2 Accident Attending 5 Pending aftar death. Director: Aft 1 Yes 2 No investigation 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and menner stated. edical 29a. Certifier Within 2 To the 29d. Dete signed (Month. Day, Year) 29b. Signatur 29c. License number

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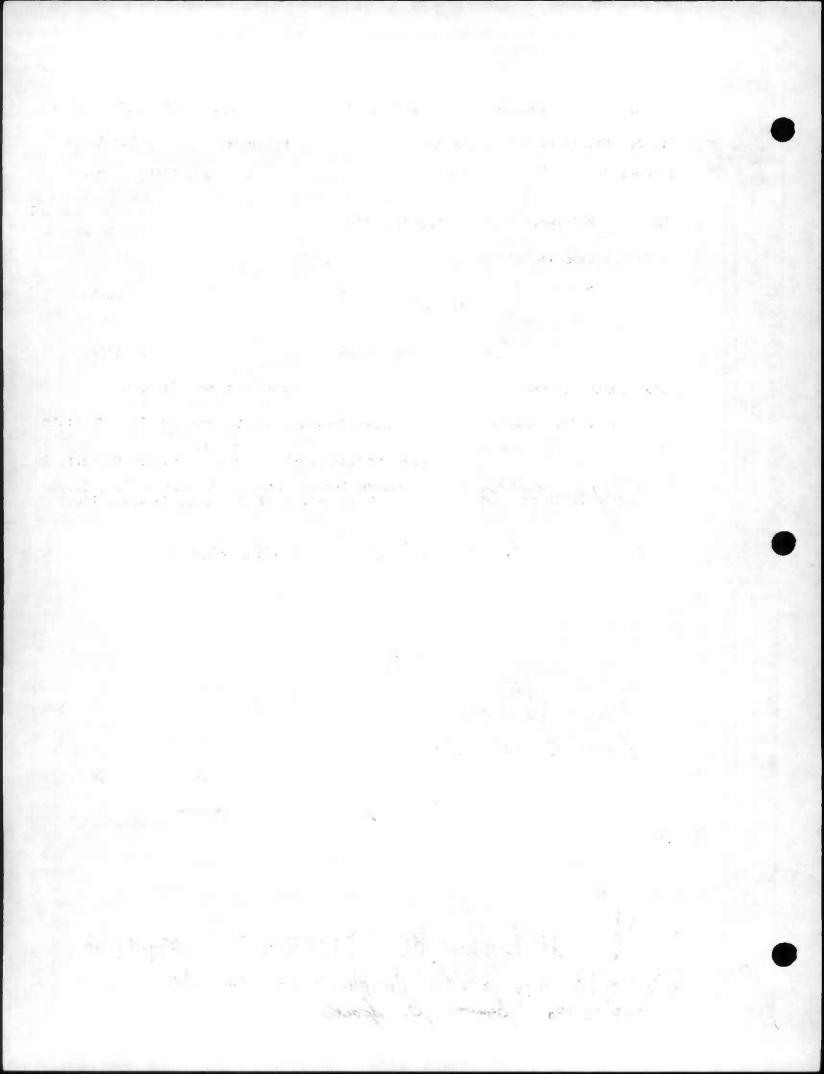
**DHMH 16 Rev 6/95** 

Registrar

31. Date filed (Month, Day, Year)

0 2 1998

Registrer's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Day Year Ρ. GRAY STEVE 10:00AM 1998 AUGUST 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, giva street and number) Anne Arundel Burnie 7720 Norfolk Road 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) May 21 1920 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stata or Foreign Months 1 1 M 2 □ F Deys Hours VIRGINIA 220-01-1223 Usual Residence of Decedent 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 1 Yes 2 Mo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21060 7720 Norfolk Road 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 YNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Tractor-Trailer 11th 18. Mother's Name (First, Middle, Maidan Surnama) 17. Father's Name (First, Middla, Last) Charles Ε. Gray Mary Childress 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 7720 Norfolk Road Glen Burnie, Maryland 21060 Helen Grav wife 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/1/98 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility STALLINGS FUNERAL HOME P.A. 3111 Mountain Road Pasadena, Maryland 21122 Approximate on each line. 3111 Mountain Road Pasadena, Maryland 21122 Approximate Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cor pulmone eers Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

**Physician** /Medical Examiner

Physician/Medical

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Certification:

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certificate

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Attending

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Division of Vital Records, P.O. Box 68760

permit. Pagas 1 and 2 should be filed will Department of Health and Mantal Hygian Important: If item 27 is marked other that any lojury or other traumatic event, the DRGs.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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r than "naturel", or items 23a or the Medical Examiner must be

filed within 72 hours aftar death Hygiana.

Directo

Funeral

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last

24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 20 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Yaar) 5 Pending Investigation

28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Chack only one)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Homicide

ts Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D44973 29d. Date signed (Month, Day, Year) 31 August

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

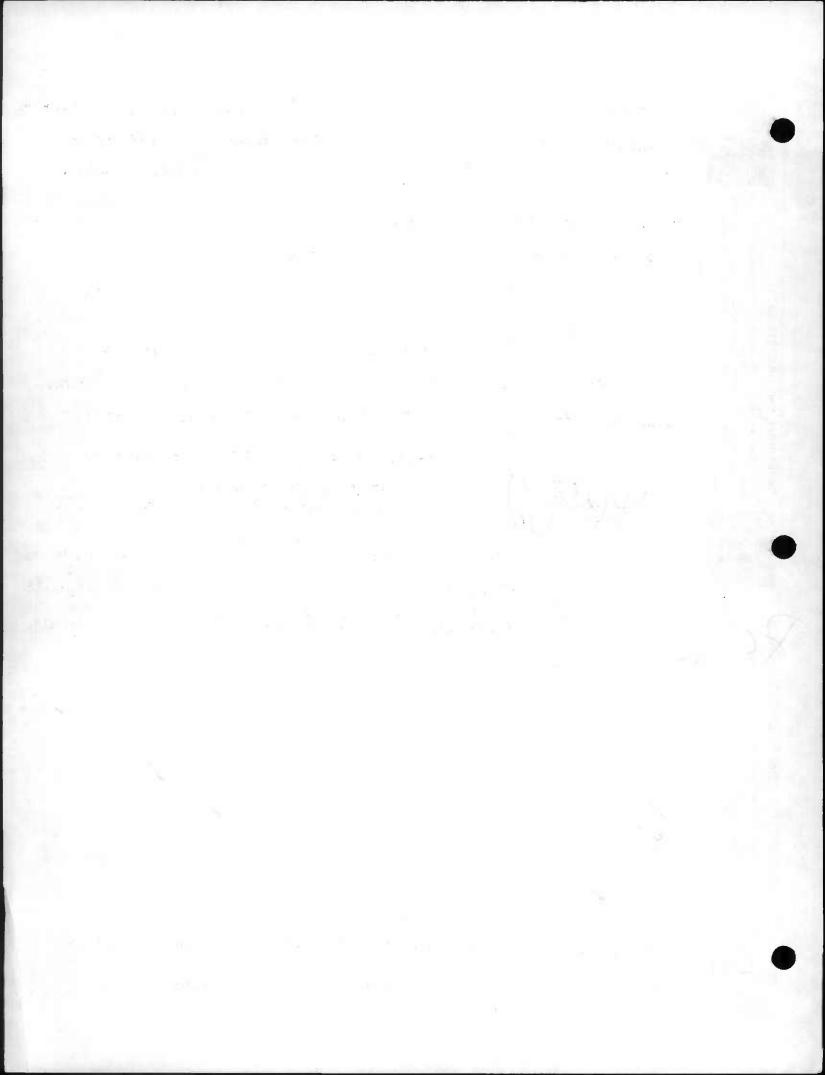
MD, 325 Hospitel Drive 202, Glen Burnue, MD GURMEET -S. SAWHNEY 2106 31. Date filed (Month, Day, Year)

State Registrar

SEP 0 2 1998

6 Could not be determined

32. Registrar's Signature



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Dete of Deeth 3. Time of Deeth 4b. City, Town, or Location of Plath 4c. Cou owar 4e. Fecility Name (If not institution, give street end number) 4c. County of Deeth BALTIMORE DGN SECOURS HOSPITAL NIA 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or rurangin Country) TAN. 30, 1928 South CAROLINA 6. Sex 1 M 2 □ F if Under 1 Year if Under 24 Hrs. Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Months Deys Hours 248-32-0993 Usual Residence of Decedent 70 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits Ves 2□No MARYLAND 10e. Street end Number 10g. Citizen of Whet Country? 1118 DARAH ANN STREET USA. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 1X Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSRUCTION COMPANY CONSTRUCTION WORKER UNKNOWN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) LSAAC JULIA (MN-UNKNOWN) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ISAAC HOWARD ce of Disposition (Name of Date 20c. Location - City or Town, Stele (50N) 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition Buriel 2 Cremation 3 Removal from State 8-21-98 LANSDOWNE, MD 4 ☐ Donetion 5 ☐ Other (Specify) MT, ZION CEMETERY 22. Name end Address of Facility 22. Name end Address of Facility 30 SEPH H. BROWN JR. FUNERAL HOME P.A. 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Approximate Intervel Between Onset end Death intra abdominal mass Immediate Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequenca of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as consequenca of) mia Due to (or es e consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probabty 4 Unknown 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a State

**Funeral** 

Director

"natural", or itams 23a or 28a-f ahow

th and Mentel Hygiene.
7 Is marked other than "natur traumatic event, the Medical

permit. Peges 1 end 2 should be file Depertment of Health and Mentel Hy Important: If item 27 is marked oth any Injury or other traumatic event

Baltimore, Maryland

Director

Funeral

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68768 P.O. Box Records, s been signed should be d certificate Division of Vital

Hospital or Attending Physician:

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After

Physician/Medical Examiner þ Completed pege 2 To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Afte completely filled in by the fun

SEP 0 2 1998

2200 1 ☐ Yes 2 ☐ No

25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 FR/Outpetient 3 DOA 28b. Time of 28d. Describe how injury occurred

27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide

28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier

Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

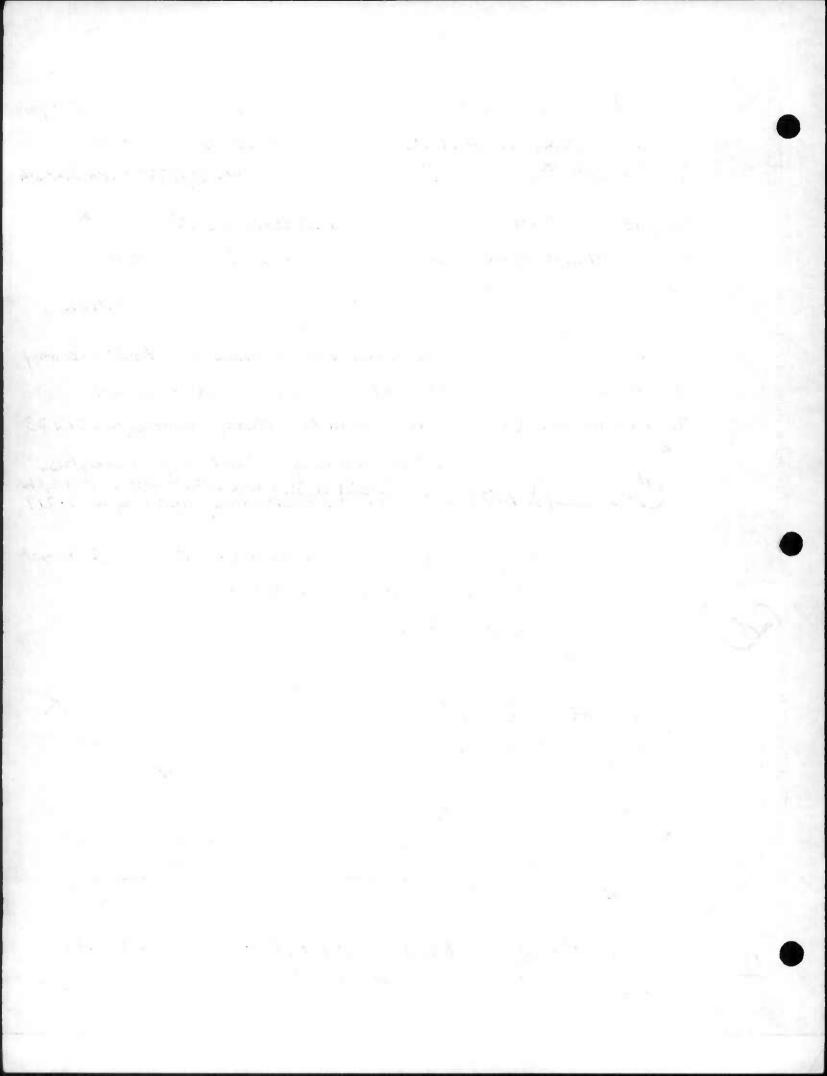
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature end title of cartifier. 29c. License number 29d. Date signed (Month, Dey, Yeer)

30. Name end eddress of person who con pleted cause of death (Item 23e) (Type, Print) Balt. MD Tean 2000 W. 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature

State Registrar

Medical

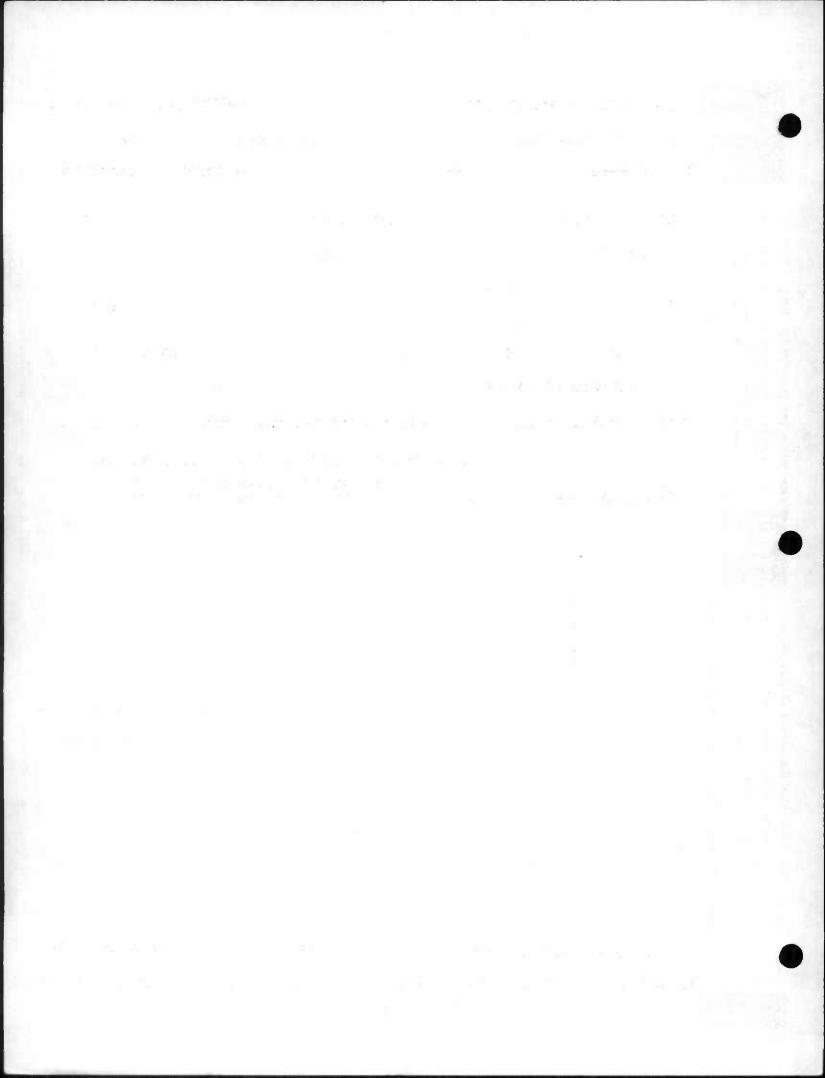


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eral ctor		210 14 24/0	- em	(In yrs. last birthda 73 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Data of Birt Month, Da 5/29	h / <del>25</del> 23	9. Birthplace (Stata or Foreign MARY LAND	
	-	Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City, Town or	Location				10d. Insida City Limits	
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noth	Director	10e. Street and Number			10f. Zip Coda	IVL		10g. Citizen of V	What Country?	
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	by Funeral	11. Marital Status  1 Nevar Married 2 Married  3 Moved 4 Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:	var In U,S. 1	3. Was Dacedant of H If Yas, specify Cub 1 ☐ Yas 25 No	dispanic Origin? (Span, Maxican, Puarto Specify:	pecify Yas or No Pican, atc.)	14. Rac Blac Specify	e - Amarican Indian, ck, Whita, atc. ': WHITE	
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8		XX0.0. W	1100000	ih:	22 Name and Addre KACZORO	WSKI FU! EET ST.				
ian	-	23a Part I. Enter the disease or court shock, or heart failure. List on his	ications that caused t ne causa on each line	he daath. Do not	antar tha moda of dyir	ng, such as cardlac	or raspiratory ar	rast,	Approximata Interval Between Onsat and Death	
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	by Physician/M	Part II. Other significant conditions co	ontributing to death but	not rasulting in the	undariying causa giv	ven in Part I.			ntribute to the cause of death? 3□ Probably 4▼Unknown	
	Completed D							an autopsy rmed?	24b. Wara autopsy findings available prior to completion of causa of death?	
	<u> </u>						101	as 2 No	1 ☐ Yas 2 ☐ No	
	3					26. Place of Daa	th (Check only o	na)		
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pietery rilled in by the funeral director	redical Certification: 10 be	axaminar? 1	28a. Data of Injury (Month, Day) 28a. Place of Injury building, etc.	Year)  28b. Time Injury  y - At home, farm, (Specify)  my knowledge, de xamination end/or	of 28c. Injury M 1 1 street, factory, office	y at k? Yas 2 □ No  ma, data and place, pinion, deeth occur a number	28f. Location (5 City or Town	Street and Numb m, State) ceuse(s) end me deta and place, to 29d. Data signed	er or Rural Route Number,	

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (19) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey ARISTON 0830 September 4b. Olty, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death BALTIMORE If Under 24 Hrs. 8. Date of Bir AGNES HOSPITAL 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 8/30/40 5. Social Sacurity Number 9. Birthplace (Stata or Foraign t M 2□ F Months Deys Hours Min. MARYLAND Yrs. 58 218-36-1391 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No BALTIMORE N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 U.S. 2320 N. ROSEDALE STREET 12. Was Decedent Ever in U,S. Armad Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Yeer or Detes: 14. Race - American Indian. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) Black, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced BLACK 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE WELDER 12 -0-18. Mother's Name (First, Middle, Maiden Sumama) 17. Fether's Name (First, Middle, Last) CATHERINE HOLLAND CARNESS BROWN 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2320 N. ROSEDALE ST.-BALTIMORE, MARYLAND PATRICIA HILL (WIFE) 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) 9/5/98 BALTIMORE, MARYLAND KING MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility ELIZABETH L. PHILLIPS, P.A. CFSX 1721-27 N. MONROE STREET-BALTIMORE, MD 21217 cin 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) EURAL EFFUSION 4 MONTHS Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last HROM BOCYTOR NUNTHS CARDIONNOBATIS EAR Part II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown LYMPROMA 24b. Wera autopsy findings available prior to completion of ceuse of deeth? HISTORY OF ALCOHOL ABUSE 24a. Was en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medicel examiner? 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

page 2 s Cartston

Physician/M

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Certification:

edical

(Check only one)

Date filed (Month, Day, Year)

SEP 0 2 1998

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23e or 28e-f short the Medical Examiner must be notified at

Hygiene.

Pages 1 and 2 should be file ment of Health and Mentel Hy ant: if flem 27 is marked oth ury or other traumatic event

Department if important: if any injury or

**Physician** /Medical

altimore,

other

72 hours efter death

Director

Funeral

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Completed

Aithin 2 To the

State Registrar

29b. Signature and title of certifier

JACK

30. Name end eddress of person who come eted causa of death (Itam 23e) (Type, Print)

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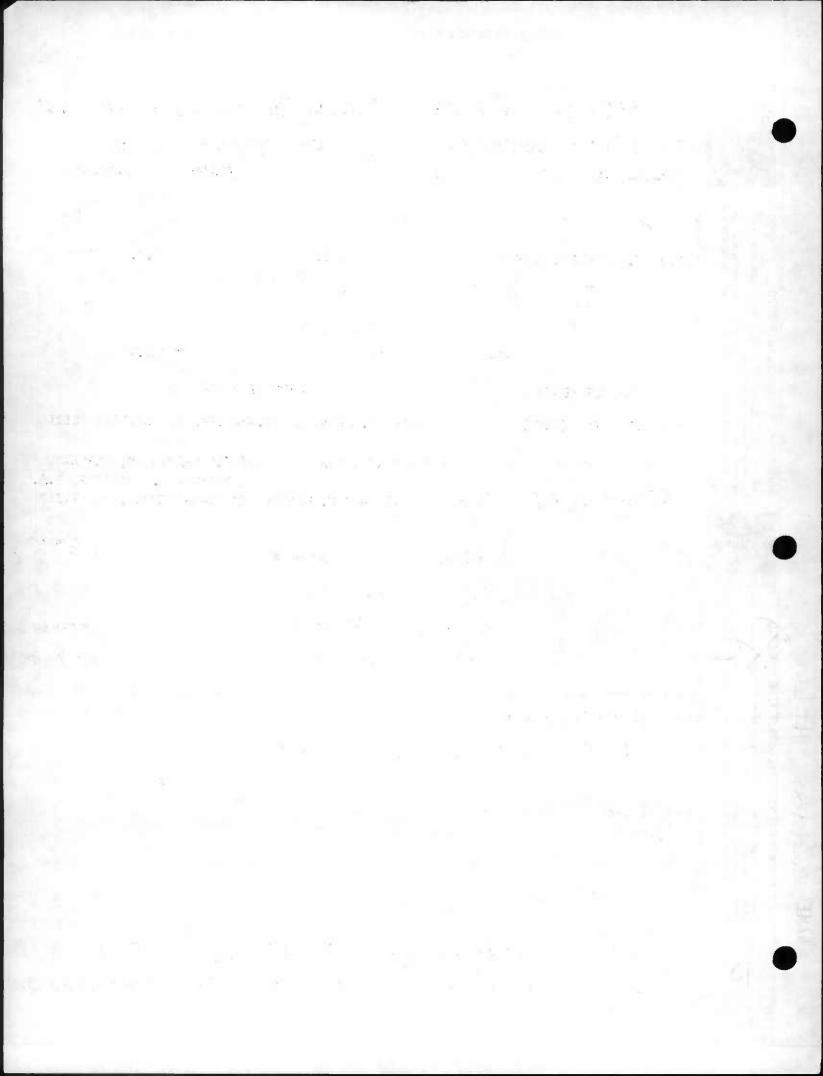
29c. License number

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and plece, end due to the cause(s) end manner stated.

29d. Date signed (Month, Day, Year)

AZ T/MURE, MD 21228

900 32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 30 1998 John M. Hamilton August /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Franklin (5. Social Security Number enter | If Under 1 Year sosedale )quare Hospital If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Months Days 562-18-3497 80 Iowa Director Mar. 9, 1918 Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show Md. 1 ☐ Yes 2 X No Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8537 Rhuddlan Road 21236 United States Funeral 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxicen, Puerto Ricen, etc.) 11. Marital Status I ☐ Yes 2 🖄 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: p White 3 Widowed 4 Divorced Yaar or Datas Completed th end Mentel Hygiene.
7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Merchant Marines Capt. amilton, 17 Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charles Hamilton Mary Benjamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) If item 27 or other tr Celia N. Hamilton (Wife) 8537 Rhuddlan Road Baltimore, Md. 21236 20b. Place of Disposition (Nama of cemetery, crametory or other place) 20c Location - City or Town, State 20a. Method of Disposition o 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 Donation 5 Othar (Spacify) Hillton Service Corp. 9/2/98 Towson Maryland for Knight Jr 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complication it is caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final . Kespiratory 30 minutes disaasa or condition resulting in death) Examiner Examiner Pheumonio latera and I-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Division of Vital Records, P.O. Box 68760, of Attending Physician: The law requires that the death certificate be en effect of the death. Physician/Medical Due to (or as a consequence of) for use es signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yee 2 No 3 Probably 4 Unknown Lungand py 24b. Were autopsy findings availabla prior to completion of ceusa ot death? Completed evious Myocardial Infarction 24a. Was an autopsy Cardiac Arrest 2 No 1 Yas 2 No revious 25. Wes case reterred to medicel examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 🗆 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner es stated.

Medical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai To the Mosp within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 30, 1998 unul 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
De Thomas Krisanda 9000 Franklin Sq 10 Drive Baltimore, Mary land 21237

32. Ragistrar's Signatura

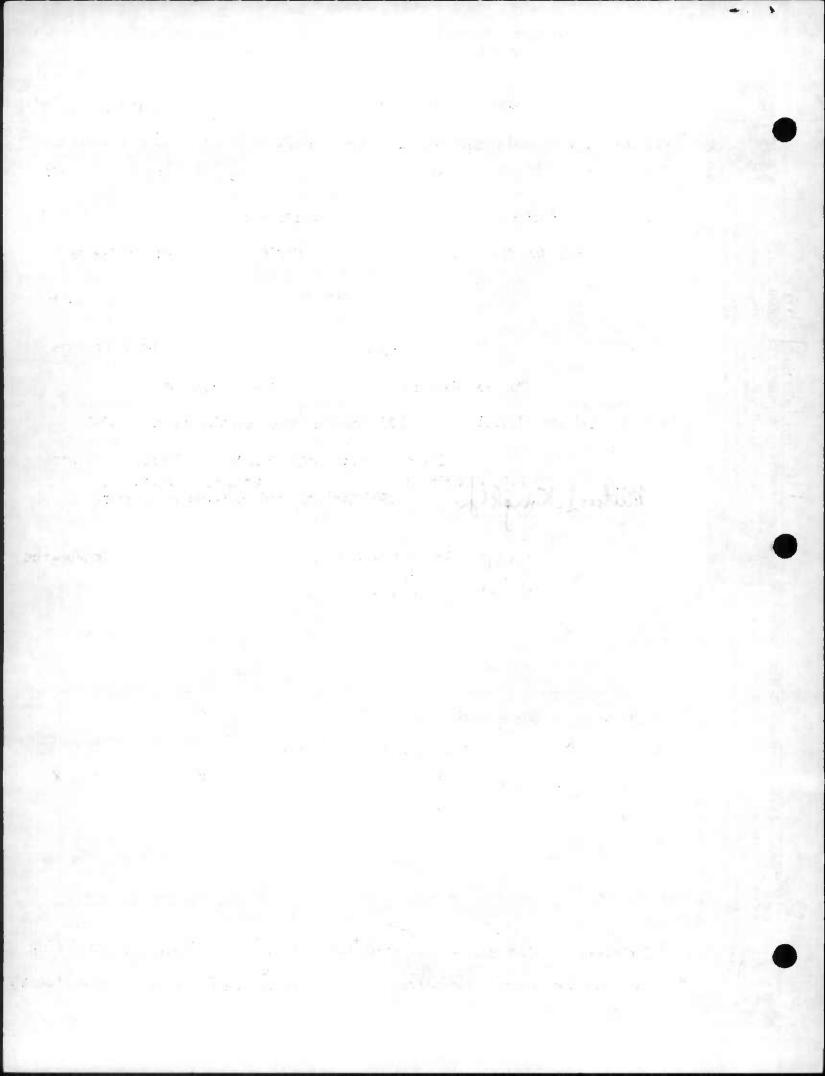
DHMH 16 Rev 6/95

State

Registrar

31. Date tiled (Month, Day, Year)

SEP 0 2 1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 2. Data of Death ecedent's Nama (First, Middla, Last) 30 **Physician** /Medical City, Town, or Location of Deeth Facility Name (If not institution, give street and number) Examiner Baltimore 9. Birthplaca (Stata or Foraign Country)

GORGIA Days **Director** with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "naturel", or fferms 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Numbe USA.

14. Raca - American Indian,
Black, Whita, atc. Funeral 1 and 2 should be filed within 72 hours after deeth Was Decedent Ever in U.S. Armed Forcas? 1 Days 2 No 01-10-51 If Yas, Giva Yaar or Datas: 01-23-57 Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 Naver Marriad 2 Married 1□ Yas 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Health end Mental Hygiene. Elementary/Secondary (0-12) Collaga (1-4or 5+) DRIVER 12 HT GRADE 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surname) KOBINSON WILLIAM GILBERT ACKSON EA ESSIE 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) NADINE DR. E 4214 BALTI MORE, MD, 21215 ate 20c. Location - City or Town, State DAVIS (DAUGHTER INDA Baltimore, 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20e. Method of Disposition Pages 1 Department of Important: If II Burial 2 Cramation 3 Ramoval from State 6 9-9-98 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Licens BROWN JR. FUNERAL HomE, P.A. 23a. Part1. Entar the disaese, or complications that ceusad tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast,

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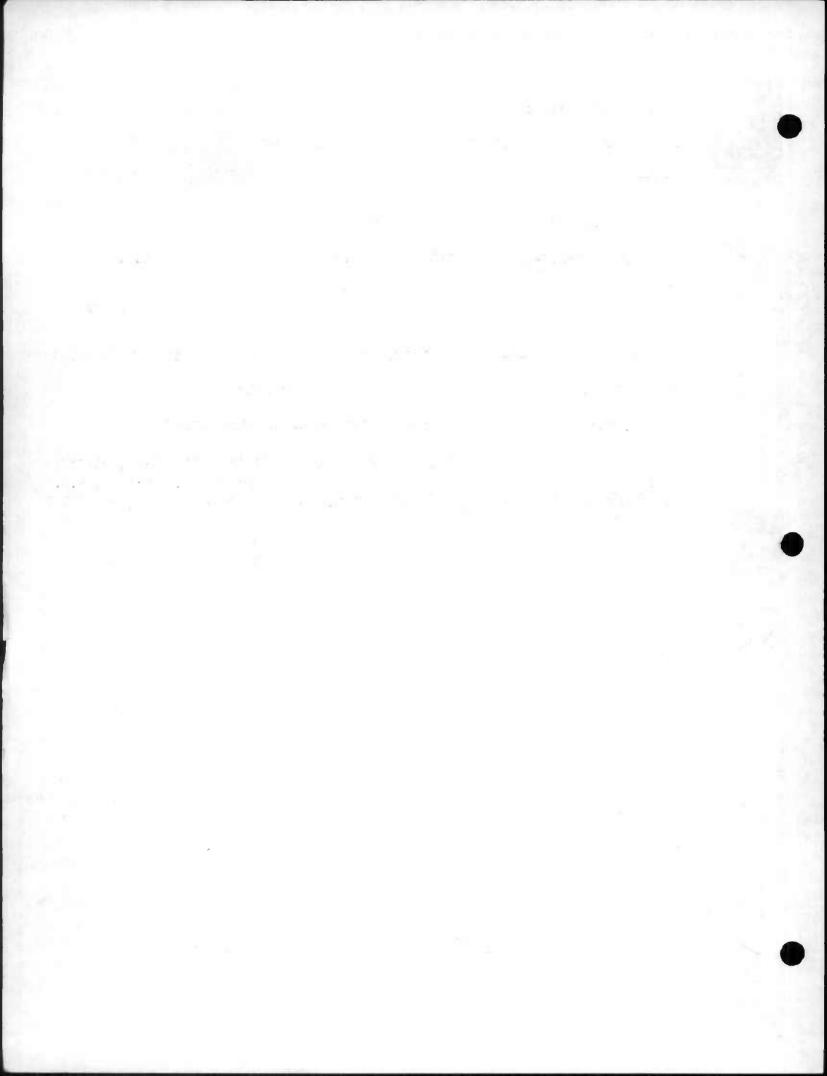
32. Registrar's Signeture

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111 Penn Street, Baltimore, Maryland 21201

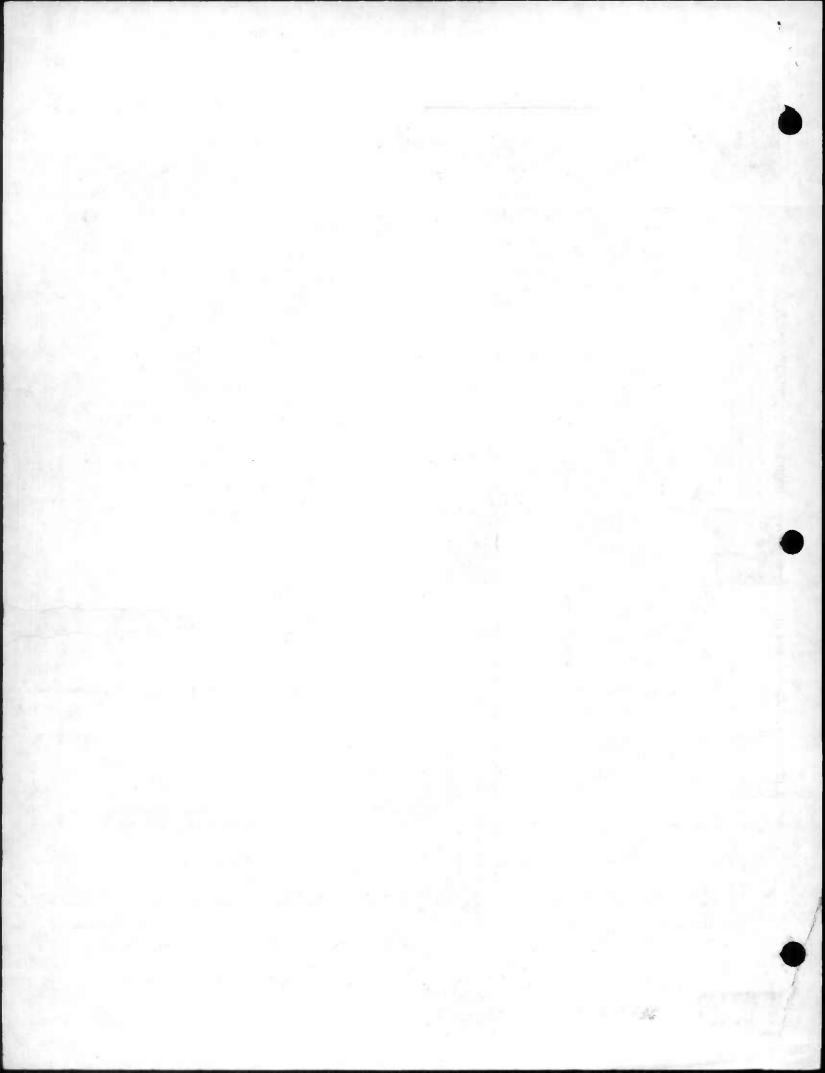
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Division  To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, ferm, secify)	street, factor	y, office	28f. Location (Si City or Town	reet and Number, Stete)	er or Rural Route Number,
DIVI: To the Hospital or Att within 24 hours aftar of To the Funeral Direct completaly filled in by	edical	29a. Certifier 1 Certifying Physical Check only one)	elcien: To the best of my keer: On the basis of examined manner steted.	nowledge, dee	eth occurred investigation	et the time, dete end pled , in my opinion, death occ	e, end due to the curred et the time, d	euse(s) end me ete end place, a	nner es steted. and due to the ceuse(s)
To the To the comple		29b. Signature and title of certifier	end manner steted.		29	c. License number	2	9d. Date signed	(Month, Day, Year)
		· Uni	MD			D52394		8-11-	-98
3		30. Name end eddress of person who co	mpleted ceuse of deeth (I	20 YU	Sive	et Baltimo	we MO	, 21:	20/
State Registra	-	31. Dete filed (Month, Dey, Year)	32. Registrer's Sig	neture	Spor	(h)			



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Linda J. Kirkman August 19, 1998 11:00p.m. 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a Baltimore Sinai Hospital If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days 1□ M 250 44 214-62-7495 Nov. 13, 1953 N.C. Usual Residence of Decedent 10c City Town or Location 10a State 10b Count 10d Inside City Limits n/a Baltimore 1 XXes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA 3923 Norfolk Avenue Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Dacedant Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, Whita, etc. 1 Never Married & Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1□ Yes 2□No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education 16b. Kind of Business/Industry (Specify only highast grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Claims Adjuster Insurance Company 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nancy R. Smith Frank Wilks 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8406 Church Lane Randallstown, Md. 21133 19a. Informant's Name/Relationship (Type, Print) sister Gloria J. Wilks 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VeteransAug. 25 Owings Mills, Md. 22. Name and Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Liouville 2501 Gwynns Falls PKWY Baltimore, Md. 21216 the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, 23a. Part1. Entar the disease, or complications that pershock, or heart failure. List only one cause of each Approximate Intervat Between Onset and Death Immediate Cause (Final 10 months Adenocarcinoma with Metastas17 disease or condition resulting in deeth) Colorectal Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2/0 No 1□Yes 2□No 26. Place of Death (Check only one)

Examine Division of Vital Records, P.O. Box 6876

**Physician** 

/Medical

Examiner

Md.

Director

Funeral

p

Completed

**Funeral** 

Director

r than "natural", or items 23a or 28a-f ahow the Meolcal Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after of health and Mentel Hygiene.
Int: If Item 27 Is marked other than "natural", or item
INTY of other traumatic event, I'm Medical Examinar
INTY or other traumatic event, I'm Medical Examinar

permit. Page Department of Important: if any injury or

**Physician** /Medical

Baltimore, Maryland 21215-0020

death with the Marylend

Examiner Physician/M signed by the P Completed certificate has t irector, page 2 s director, Be 10 this funeral Certification: After

Hospital or Attending 24 hours after death. after deat filled in

To the Hosp within 24 hor To the Fune completely fi

24 hours

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Dete liled (Month, Day, Year)

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 1 ☐ Yes 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No 2 ☐ Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29d. Date signed (Month, Day, Year) 29c. Licensa number

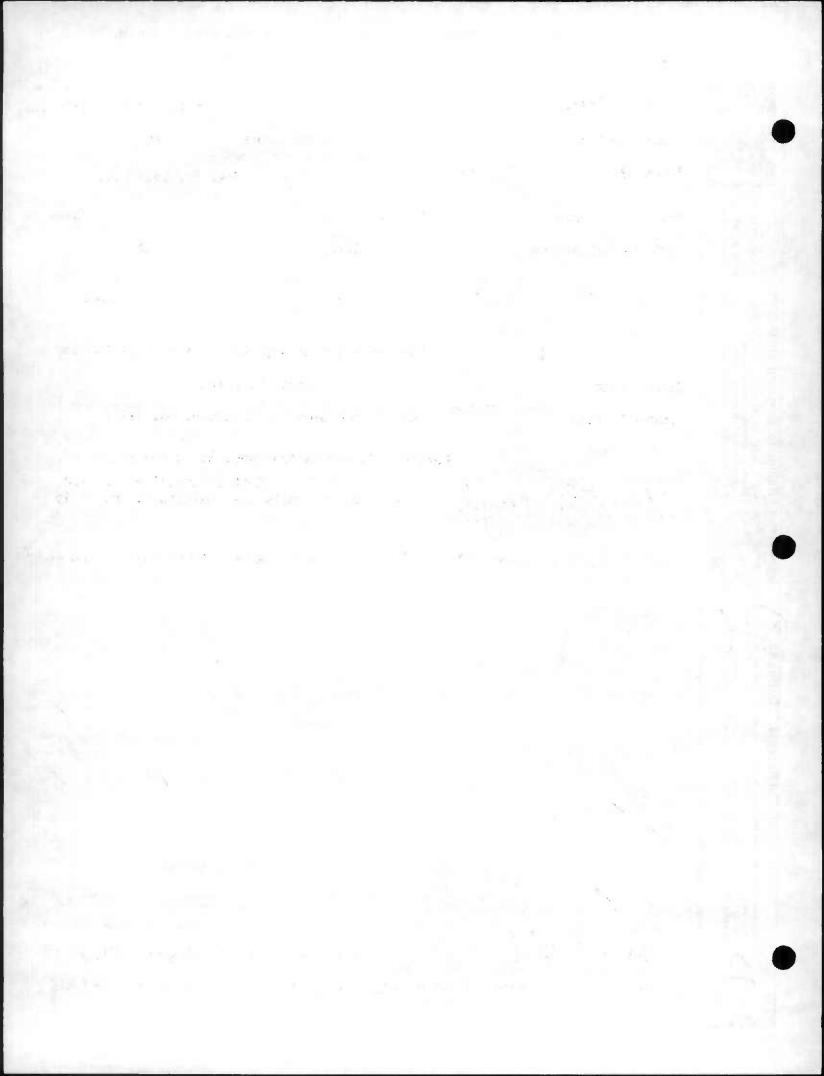
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AS2402321/MIT9191 AUGUST

Ities Michael

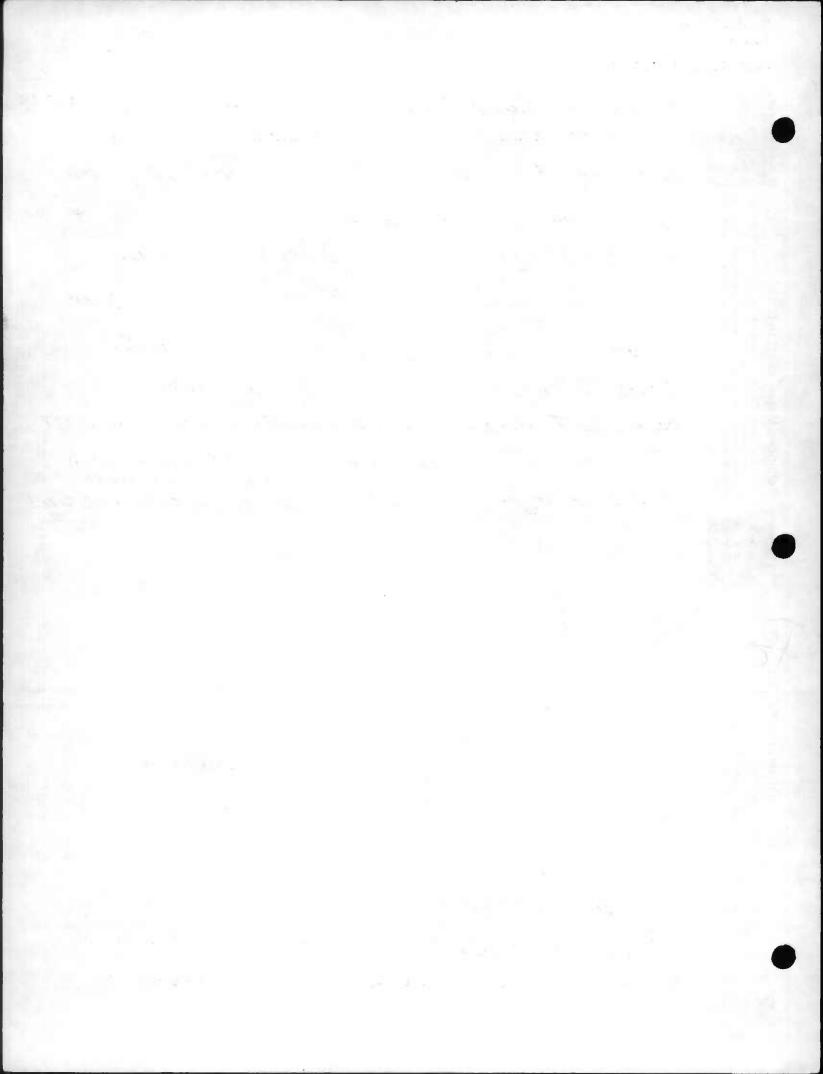
Sinni 2401-W Belvedere. Hospital of Bulto 32. Registrar's Signature

SEP 0 2 1998



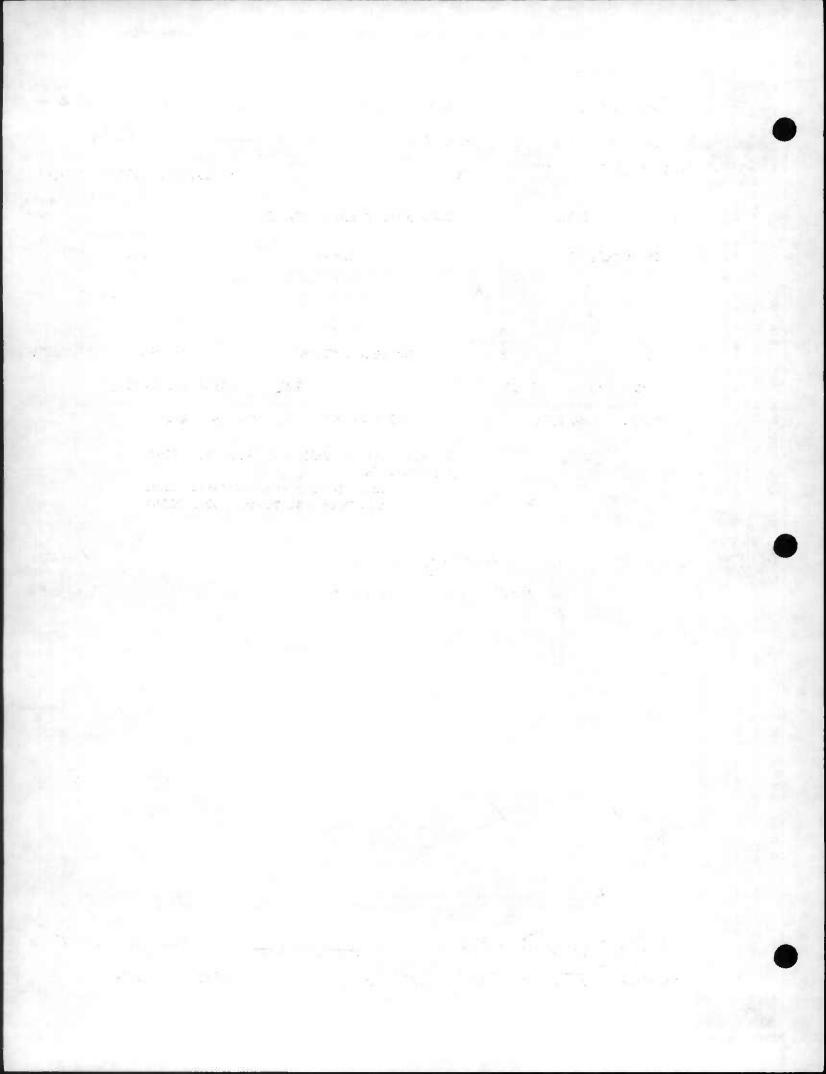
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Physician /Medical	1. Decedent's Name (First, Middle, Last, Gre Gory	Kemp-J	effers			2. Date of De Month	Day 23, 199		3. Time of Death 11:55 AM	
Examiner	4e Fecility Name (If not institution, give 2211 BROOKFIELI				tb. City, Town, o	r Location of Deet RE		of Death VA		
Funeral Director	660-64-4098	7. Age (In yrs.	lest birthday) If Ur Yrs. Mont	nder 1 Year ths Days	If Under 24 H Hours Mi		rth ey, Year) B-57	9. Birthpla Country	ce (State or Foreign	
show	Usuel Residence of Decedent  10a. State 10b. County		y, Town or Location			1/2-01-02		100	I. toside City Limits	
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or he or he	11. Marital Status  1 Never Married 2 Married	12. Wes Decedent Ever in U, Armed Forces? 1 Yes 2 1 No		ecedent of H specify Cuba		(Specify Yes or Nerto Rican, etc.)	0- 14. Race Black Specify:	- American k, White, et		
15-0020 n 72 hours efter "natural", or to suited Exercise	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Edu	Year or Dates:	16a. Decedent's l	Jsuel Occup	ation		16b. Kind of Bu	siness/Indu	stry	
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Aaryla 2 should bend Men 1s marke raumatic	19a. Informant's Name/Reletionship (T)			ress (Street	end Number or	Rurel Route Numb	oer, City or Town,			
Ore, jes 1 an of Heel of Heel or other	Michael Scott		ZZ37 Place of Disposition emetery, cremetory	(Neme of or other ple		Date	20c. Location	City or Tow	n, Stete	
int:	4 Donation 5 Other (Specify)	/	MT. ZI	ON	on of English	9-1-98	Lansdo	were!	nD.	
Balt permit. Depart Importa	21. Signature of Funeral Service Licens		120 Nam	e and Addre	,		rylie =			
Physician /Medical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only of limmediate Cause (Finel disease or condition resulting in death)	ACQUIRED IMMUN		CY SYNDE	ng, such es cerd	lac or respiratory	errest,	1	Approximate Interval Between Onset and Death	
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be secuted business of business at Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es e consequence of):								
Medic	that initiated events resulting in death) Last	Due to (o	r es e consequence	of):						
O. Box	Pert ti. Other significant conditions cor	ntributing to death but not resi	ulting in the underlyi	ng cause giv	en in Part I.	23b. Did	i tobacco uae cor	ntribute to 1	he cause of death?	
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	30. Name and address of person who co	. KORFIL IM	. 111 Penn	Stre	et, Balt	timore, N	Maryland	21201		
State Registrar	SEP 0 2 1998	32. Registrar's Signa	9. Spa	Ms						



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Department Important: It any Injury o phos.	21. Stocature of Funeral Service Licenses CREMATORY, Name and Address of Facility Ruck Towson Funeral Home, In								, Inc.		Q P-2	
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0	30. Name and address of	-	mpleted ceuse of	of death (Ite	m 23a) (Type, F	Print) S6. L	Balt.	more	, MO	2128	27	



Division of Vital

State Registrar

1shports 31. Data filed (Month, Dey, Year) SEP 0 2 1998

29b. Signatura and titla of certifie

29a. Cartifiar

Medical

- Where Maryland 21201 32 Registrar's Signature

30, Nama and address of person who completed causa of death (Itam 23a) (Type, Print)

1 Cartifying Physician: To the best of my knowledga, daath occurred at the time, date end plece, end due to the cause(s) end menner es stated.

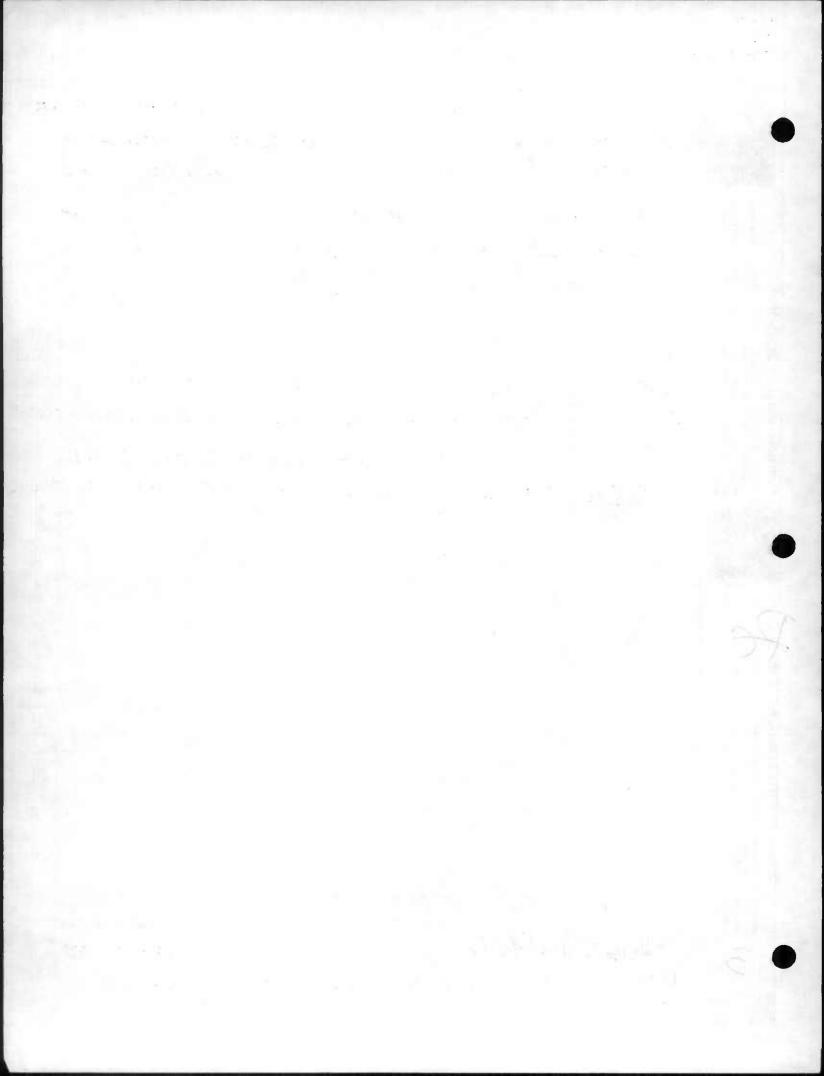
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred et tha tima, data and place, and dua to the cause(s) and mannar stated.

29c. Licansa number

O.C.M.E.

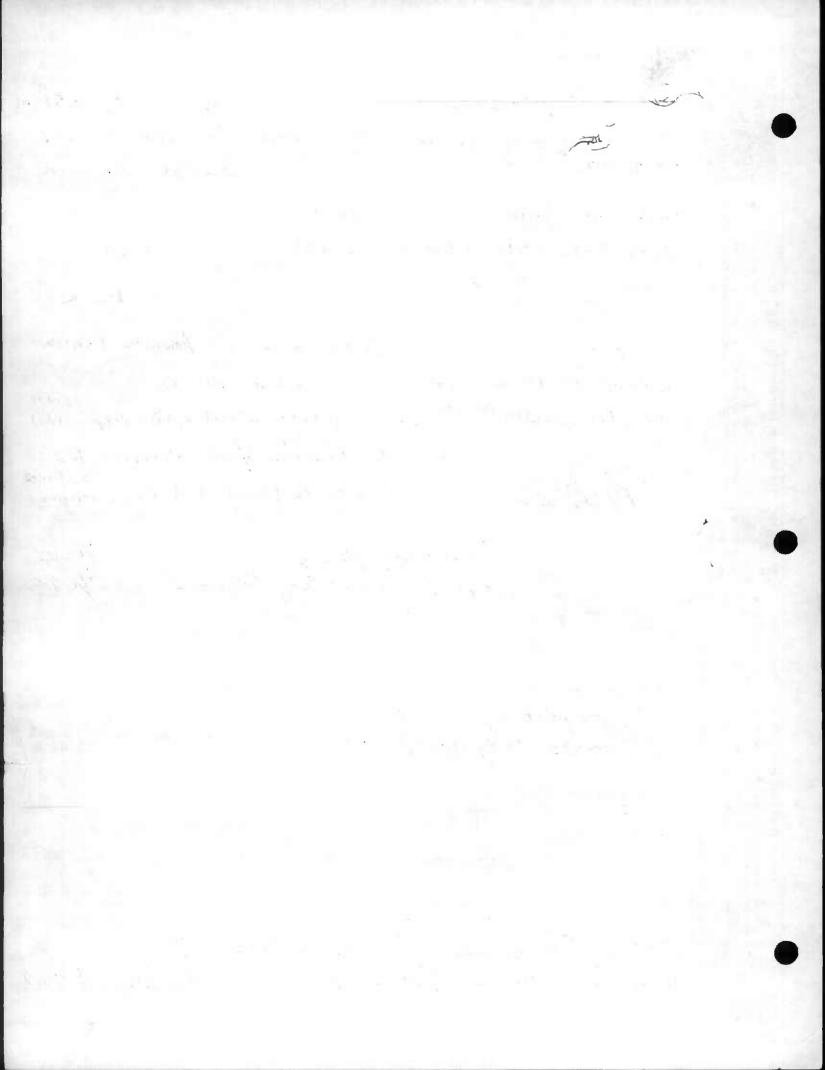
29d. Data signed (Month, Day, Year)

AUGUST 30, 1998



	MD Film G763 9-2-98RC State of Maryland / Department of Health and Ment  Certificate of Death	Reg. No.	26822
Physician	O RUSALIF F. MITCHELL	ate of Death Ionth Day Ye	
/Medical	4h City Town or Location		198 11.51AN
Examiner	Annapolis Nursing & Rehab. Center Annapol		ARUNdeL
Funeral Director	5. Social Security Number  5. Social Security Number  6. Sex  1 Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  Wonths Days Hours Min.  (A)	ate of Birth 9.	Birthplece (State or Foreign Country) ARRY Land
the Menyland 28a-f show periland	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  MARYLAND Anne Arundel Annapolis		10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
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Maryland nd 2 should be file lith end Mentel Hy 87 is marked other r treumatic event To Be (	19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street end Number or Rural Roll Angel A Langston 1908 Cope Land Str	not 1 1 1	ne, zip Code) 21401 napolis Mi)
altimore, mil. Paget 1 a partment of Hea cortant: If Hean I Injury or othe	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Nna Polis Memorial 8/2,		or Town, State
Denuit. Departmingorta any inju	21. Signature of Fundamental Service Licensee  22. Name and Address of Facility  Seff Miller House	5 11 1 5	1922 Forest
Physician	23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resistance or heart feiture. List only one cause on each line.		Approximate Intervel Between Onset and Deeth
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Hospi 24 hou Funer tely fil	29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and death occurred et the time, date and placa, and death occurred et and manner stated.		
To the vithin 2 To the comple	290. Signatuser and filte of pertifier 29c. License number 29c. Li	29d. Date signed (N	fgnth, Day, Year)
3	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  HOCHMAN U.D., 1833A FAREH	n. Annande	Tend 2140
State	31. Date filed (Month, Day, Yeer) AUG 2 6 1998  32. Registrar's Signature  4. Aparth	7, 7,	

DHMH 16 Rev 6/95



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2055 Miller August 29 1998 Ruth 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth N/A Union Memorial Hospital Baltimore if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1□ M 25 F Days 57 Yrs. 220-38-6640 Jul 2, 1941 Maryland Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 No Yes 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3939 Roland Avenue 21211 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indien. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Giant Food Co. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Joseph Studer Germaine McGowan 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 542 Fifth Avenue, Baltimore, Maryland 21227 Germaine Garrett (Daughter) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from Stete Green Mount Cemetery 8/31/98 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility A. Alan Seitz, Jr. Funeral Home Kan 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Dystenction Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown atrial Fibrillation 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 ☐ Yes 2 No 25. Wes case referred to medicel exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Date of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Yes 2 No investigation

Examiner in and Physician/Medical Division of Vital Records, P.O. Completed has or Attending Physician: director Be 2 funeral Certification: aftar death. 24 hours a Hospital

**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

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**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahov any Injury or other traumatic event, the Medical Examinal mounts on nother

**Physician** /Medical

Examiner

1 Yes 2 No 27. Manner of Deeth 1 Naturel 2 Accident 3 Suicide

6 Could not be determined 4 Homicide 29a. Certifier (Check only one)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Dev. Year)

em Woller

AU4176436M9835

Baltimore, MD

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Robin Motter, D.O. 2400 Bytham Ct. 303 31. Date filed (Month, Day, Year)

State Registrar

Medical

SEP 0 2 1998

strer's Signature

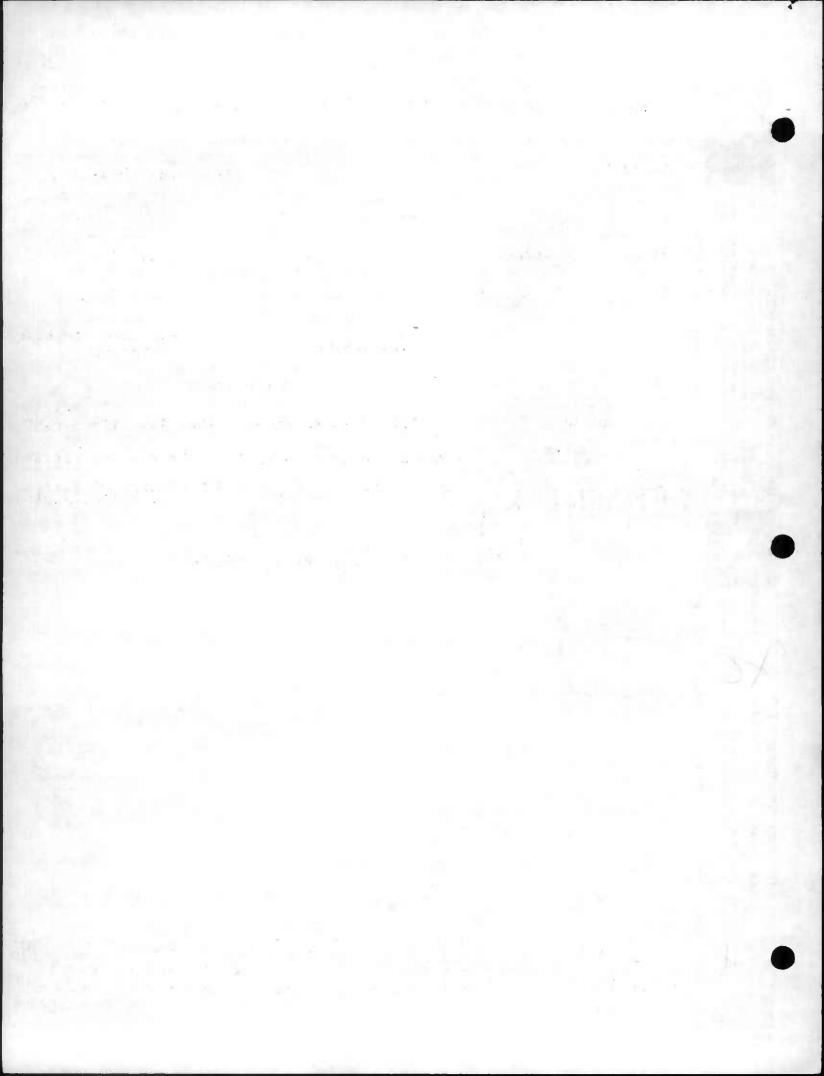
To the Hosp within 24 hor To the Fune completaly fi

AND REAL PROPERTY LAND egitario il archio 1540 ACT NAME OF STREET (Miles benefit and processing in a process of the contract of Contract process of the second second

## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 35 **Physician** MC DONALD 10 ALPHONZO 1998 AUG 30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMOR SECOURS HOS PITAL If Undar 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1DEM 2DE 213-78-1851 Yrs. 35 Director 08/01/1963 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No MD N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with "natural", or items 23s or 28 N. Mount Street 21223 U.S.A. death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas ② ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines once. Black, White, etc. Never Marriad 2 Married 1 Yes 2 XNo Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland Racetrack Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Authority 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Father's Name (First, Middle, Last) David McDonald Edith Green 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2.1.2.4.4 19a. Informent's Name/Relationship (Type, Print) Anne Saunders 8325 Western Winds Drive, Randallstown, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Ramoval from Stata Baltimore, Maryland Metro Crematory 9/1/98 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
LEROY O. DYETT & SON FUNERAL HOME, 21. Signature of Funeral Sarvice Lice 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or the disease, or complications that stated the death. Do not enter the mode of dylng, such as cardiac or raspiratory arrest, heart failure. List only one cause on the fine. **Physician** eficiency Syndrone /Medical Immediate Cause (Finel disease or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Physician/Medical that initiated events resulting in death) Last Due to (or as a consaquence of): 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed to d be det à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1□ Yas 2 No 1 Yes 2 No certificate 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 No 1 Pinpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? Attending 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 6 Funeral 29a. Certifier in Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner es stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 25 To the To To the F 29b. Signature and title of certifier 29c. License numbar 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) Securs es wy Baltune 3000 W. r, Bulto, 31. Date filed (Month, Day, Year) Registrar's Signature 21223 State SEP 0 2 1998 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Veer **Physician** Anthony C. Matuszewski 9:00 P.M. August 1998 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner 417 Sudbury Road Linthicum Anne Arundel If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1XXM 2□ F 55 Director 219-40-1344 March 13,1943 Maryland Usual Residence of Deceden the Maryland r 28a-f show 10a. State 10c. City. Town or Location 10d. insida City Limits 10b. County 1 Yas XXNo Anne Arundel Director Maryland Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or items 23s or the Wedical Examiner must be 417 Sudbury Road 21090 U.S. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married Married altimore, Maryland 21215-0020 1 Yes 2♥ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. Etementery/Secondary (0-12) Coltege (1-4or 5+) Steam Fitter 12th Grade Poole - Kent 18. Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill rinent of Haalth and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Anthony Matuszewski Pauline Gregorek 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Matuszewski / Wife 417 Sudbury Road Linthicum Md 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 8/31/98 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility George J. Gonce Funeral Home 21. Signature of Funeral Servica Licensee P.A. 4001 Ritchie Highway, Baltimore, Md 21225 mus ramerous divations that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she cause on each line. 23a. Part 1. Enter tha diseese, or col Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Metastatic Pancreatic cancer one month Examiner Due to (or as a consequenca of): Examiner cuan and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as a consequence of) Physician/Medical Dua to (or as a consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 8 24b. Were eutopsy findings available prior to complation of cause of deeth? 24a. Was an autopsy performed? Completed paga 2 s has 1 Yes 2 No 1 ☐ Yes 2 No certiticata 25. Was case referred to medical 26. Plece of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 SesIdenca 6 Other (Specify) 1 Yes 25 No 5 this tuneral 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t or Attanding 1 BNatural 5 Pending investigation 1 Yes 2 No death. 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical completaly To the Vithin 2 29d. Date signed (Month. Dav. Year) 29b. Signature and title of cartifier 29c. License number to MO August 28 1998 474CM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abenaz Brewster MD Johns Hopkins Hospital 31. Date filed (1977) 7 2 1998 32. Hegistrar's Signature State Registrar

TE STATE THE THE THE TENTON OF THE ROLL SECTION OF STREET AND ADDRESS. 

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** BARBARA MARINAN AUGUST 31, 1998 16:35 PM /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Deys 1 M 2 TF Yrs Director 60 Aug. 31, 1938 045-30-1487 Ca. Usuel Residence of Decedent the Maryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10b. County 1 ☐ Yes 2 ☒ No Directo Middlesex Cromwell. Conn. 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examples in that be no page. 17 Hawthorn Ct. 06460 IISA Funerai 14. Race - American Indian. 12. Was Decadant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☒ Divorced White Completed 16a. Decedant's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) 12 Self employed Machine Shop 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Bentzinger Iola Robert George 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) PO Box 605 Higganum, Conn. 06441 Mr. Sean Marinan/son 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 Burial 2 Coremetion 3 Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 9/1/98 Towson, Md. 21204 Hilltop Service Corp. 22. Nama end Address of Fecility Ruck Towson Funeral Home, Inc. 23a. Part1. Entar the disease, or complications that caused the death. Do not anfer the mode of dying, such es cerdiac or respiratory errast, shock, or heer feilure. List only one ceuse on eech line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition rasulting in daath) /Medical a CORONARY ARTERY DISEASE Examiner SIX DAYS Due to (or as e consequence of): Physician/Medical Examiner UNKNOWN b. HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in daeth) Last Due to (or as e consequence of) that the death certificate be dive Division of Vital Records, P.O. Box 68760. UNKHOWN · HUPERCHOLESTEROLEMIA Due to (or es a consequence of): SB esn signed by the a d be detached f 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 3 Probably 4 ☐ Unknown 1 Yas 2 No MITRAL VALVE PROLA PSE þ 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24a. Was an autopsy Completed certificate has b director, page 2 s 20 No or Attending Physician: Be 25. Wes cese raferred to medicel examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1□ Yes 20 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA this 28a. Date of Injury (Month, Dey Year) funeral 28b. Time of 27. Mennar of Death 28c. injury at Work? 28d. Describe how injury occurred Certification: Affer s after dec. 5 Panding investigation 1 Yes 2 No 2 Accident A 24 hour.

The Funeral Director of the Funeral Direct 6 Could not be determined 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stata) 3 Suicida 28e. Place of Injury - At home, farm, streef, factory, office building, atc. (Specify) 4 Homicida Cartifying Physician: To the bast of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) and manner stated. 29a. Certifiar Medicai (Check only one) To the I within 2 To the I complet 29d. Dafa signed (Month, Dey, Year) 29b. Signature end title of certifier 29c. License number

Registrar

32. Registrar's Signetura

pto Wagner, HD

Wagner

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

Johns Hopkins Hospita

RES-000

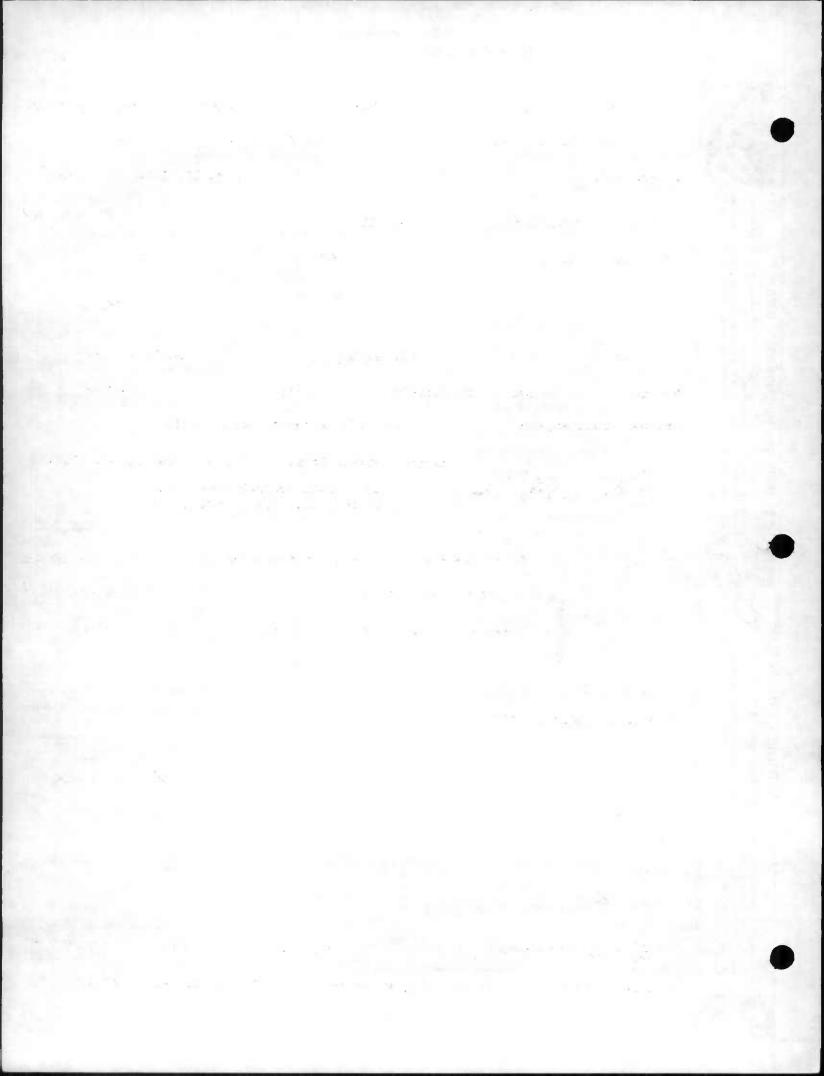
BALTIMORE, MARYLAND 21287

AUGUST 31, 1998

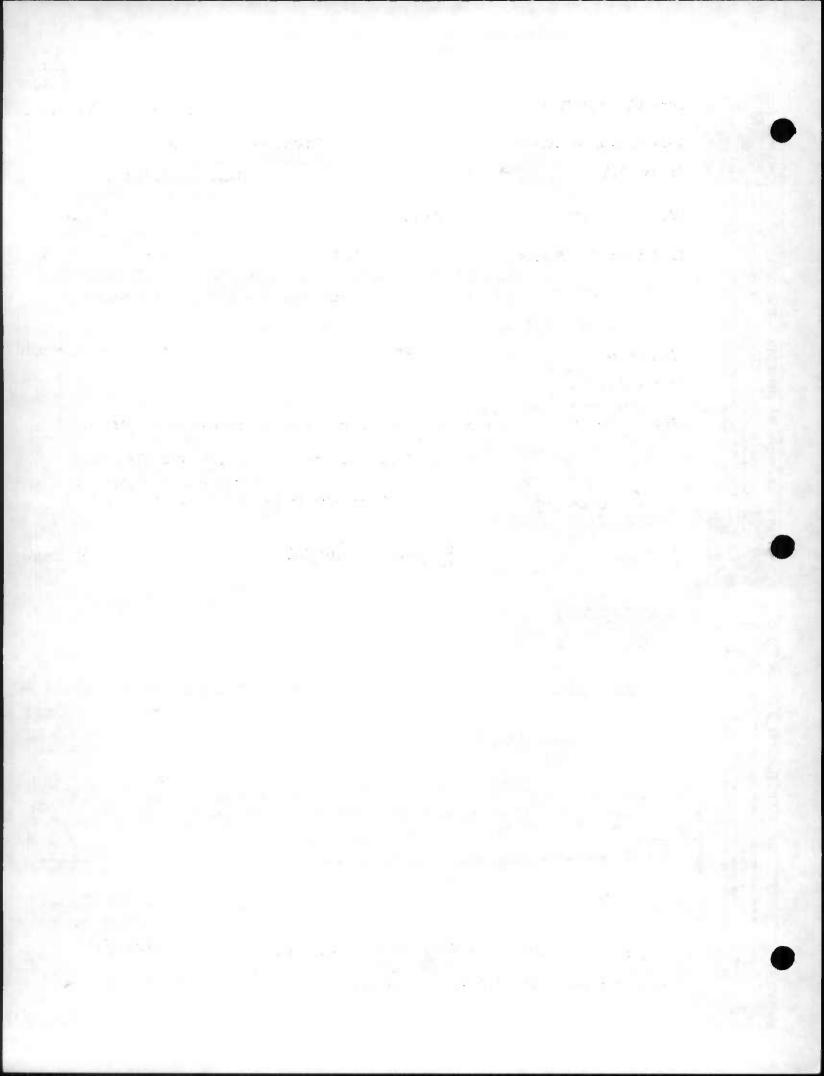
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31. Dafe filad (Month, Day, Year)



1. Decedent's Nam	e (First Middle 1 =	ist)		Ce	rtificate (	or Death	2. Dete of D	Reg. No.	26827	
Ruth Virg							Month	Dey	Year	
4a Fecility Name (			mber)			4b. City, Town,	or Location of Dea	26 1998 th 4c. County	10:20p.m.	
1002 Ashk						Baltimo	re	n/a		
5. Social Security N	lumber 6. S	Sex	7. Age (In yrs.	lest birthday)	If Under 1 Y	ear II Under 24 H		irth	Birthplace (State or Foreign Country)	
219-30-23	040	1□ M 250€	75	Yrs.	MOTITIS	ays Hours IV		20, 1923		
Usuel Residenca o	Decedent 10b. County		10c Ci	ity, Town or Lo	ocation				10d. Inside City Limits	
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10e. Street end Nu					10f. Zip Coo	de		10g. Citizen of W	/het Country?	
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11. Meritel Status	701 CO11 DC	12. Wes Dec	edent Ever in U	J,S. 13.	Was Decedent	of Hispenic Orlgin?	(Specify Yes or N	o- 14. Race	- American Indien,	
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(Sne	15. Decedent's E	ducation		16e. Dece	dent's Usuel Oo	ccupetion	vodkina	16b. Kind of Bu	siness/Industry	
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17. Fether's Name Alonza Jo		,				16. Mother's P	Telle (FIISI, MIDDI	e, maiuen surnem	e, arriviowri	
19a. Informant's N		Tune Printl	3	19h Maiti	inn Address /St	reet end Number or	Rural Route Num	her City or Town	State Zin Code)	
Deborah I										
20a. Method of Dis	-		20b.	Place of Dispe	osition (Name o	of	Date Ba.		Md. 21218 City or Town, State	
	☐ Cremetion 3 ☐ 5 ☐ Other (Specif		State		netory or other  1 Cemet		Sept. 1	Brookly	m. Md.	
21. Signature of Fu			1000					-		
F	1.000	1							omes, Inc. Md. 21216	
23a. Part 1. Enter 1	he diseese, or com	cations that	caused the dea			dying, such es card			Approximete	
Snock, or nea	irt tallure. List only	gne cause on	eech line.		^				Intervel Between Onset end Death	
Immediate Cause disease or condition		15.5	R	noort	- (2)	more			& wanto	
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resulting in death)	Last		Due to (	or as e conse	quenca or):					
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Pert II. Other signif	ficant conditions	contributing to c	leath but not re-	sulting in the u	anderlying caus	e given in Pert I.	23b. Dio	tobacco use cor	ntribute to the cause of death?	
								Yee 25 (No	3 Probably 4 Unknown	
								s en eutopsy formed?	24b. Were autopsy findings available prior to	
									completion of cause of deeth?	
100.5							1	Yes 20 No	1 ☐ Yes 2 ☐ No	
25. Was case refer examiner?	red to medical	Hamital					Death (Check only	one)		
1 Yes 25				ER/Outpetie		Other: 4 Nursin		sidenca 6 Oth		
27. Manner of Deat	5 Pending		of injury oth, Dey Year)	28b. Time of Injury	M 28C.	Injury et Work? 1 Yes 2 No	288. Describe	how injury occurr	90	
2 ☐ Accident 3 ☐ Suicide	Investigatio	e con Blan	a of Injuny - At h	nome larm st	reet, factory, of		28f. Location	(Street end Numb	er or Rurel Route Number,	
4  Homicide	determined	build	ling, etc. (Speci	ify)	root, ractory, or	1100	City or T	own, State)		
29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner es steted.    Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s)										
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(Check only one)	title of certifier	lons,	M Do	m 23a) (Tvpe	C	30929		8/2	d (Month, Dey, Year)	
(Check only one)  29b. Signature and	title of certifier	lons,		m 23a) (Type	C	30929	TIME	8/2		



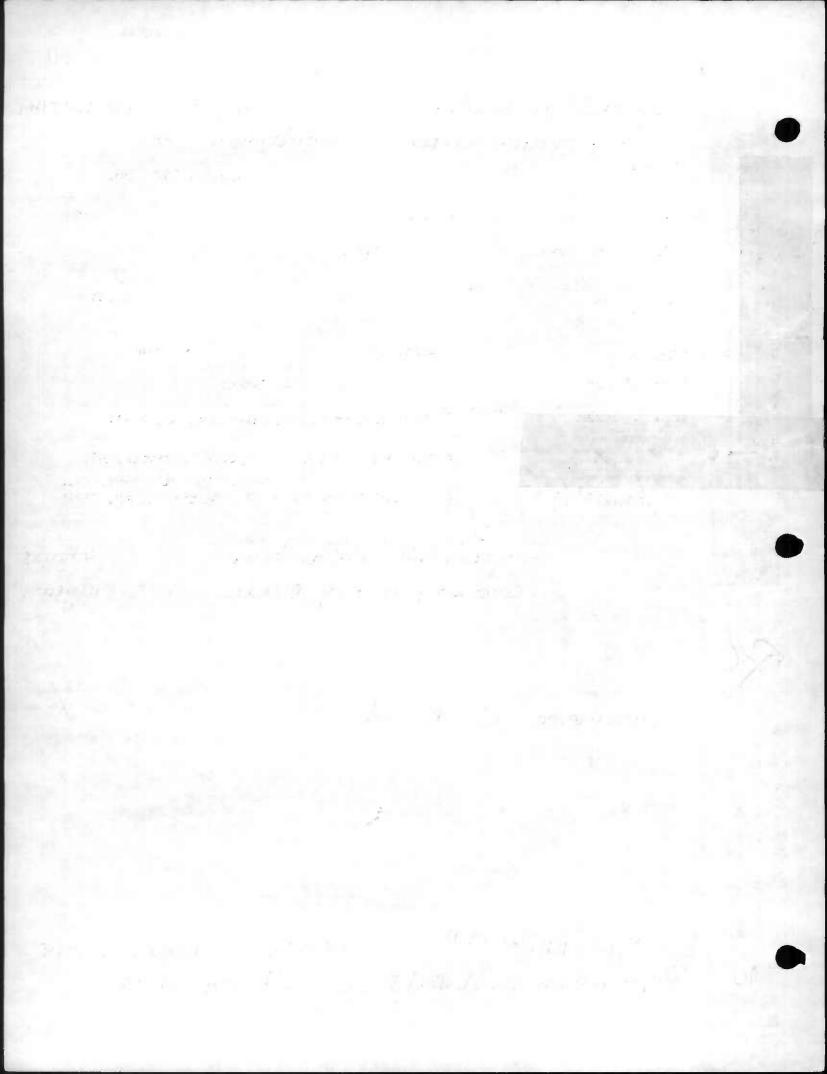
		1. Decedent's Nam	e (First, Middle,	Last)					2.	Dete of De	Reg. No.		3. Time of Death
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ToE				terworth						cAnall	•		
	1	19a. Informant's Na	me/Relationshi		000		g Address (Street						
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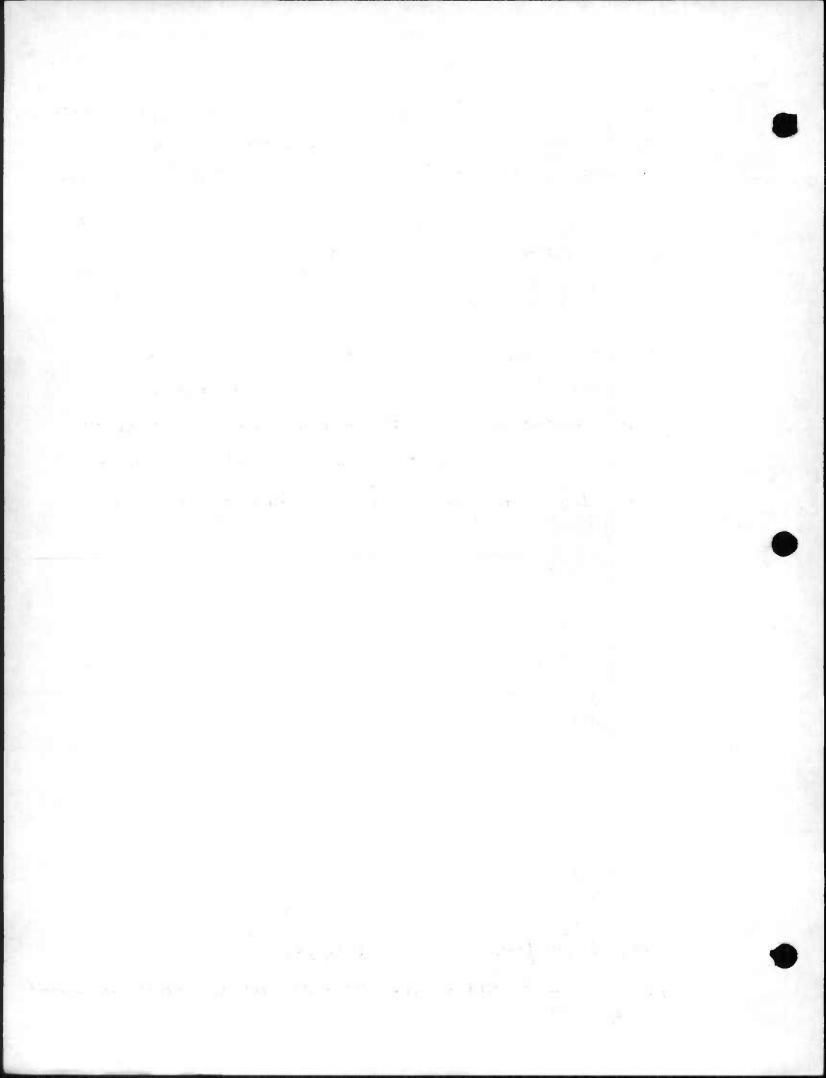
				Certifica	te of Deat	h	Reg. No.	0 4	.0023		
	1. Decedent's Name (First, Middle, La	st)		0		2. Dete of Month		Yeer	3. Time of Deeth		
Physician /Medical	Lillian	I,		Ru.	022	Augus		998	0600		
Examiner	4a Facility Neme (If not institution, giv					Town, or Location of D		y of Death			
	Northwest Hosp					ndullstown		Baltmore			
Funeral Director	5. Social Security Number 6. S 245-14-7950 Usual Residence of Decedent	7. Age	(In yrs. last bii	Yrs. If Und Months		of Birth th, Dey, Year)  9. Birthplace (Stete or Fore Country)  NORTH CAROLIN					
land w	10a. State 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limits		
Mary Fed to	MARYLAND ANNE AR	UNDEL	GLEN B	URNIE					1 ☐ Yes 2 🔀 No		
with the Ma 3a or 28=f a It be notified		N COURT CI	RCLE	10f. Z	ip Code 21061		10g. Citizen of U.S.		ry?		
d within 72 hours efter death with the Manyland d within 72 hours efter death with the Manyland diener a sale or 28s-f show in the motified at the Medical Examiner must be notified at completed by Funeral Director	11. Mantal Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	ver in U,S.	13. Was Dec	ecify Cuban, Mexic	Origin? (Specify Yes or can, Puerto Rican, etc.		ce - Americe eck, White, e	tc.		
ed within 72 hours ygiene. The Medical Exit.	15. Decedent's Ed	ducetion	16a	Decedent's Us	ual Occupation rork done during m use retired)	net of working	16b. Kind of E	Business/Indu	ustry		
within 7 within 7 within 7 than "n tha "n than "n than "n than "n than "n than "n than "n than "n tha	(Specify only highest green Elementary/Secondery (0-12)	College (1-4or 5-	-)	life. DO NOT	use retired)	ost of working					
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should be and Mental of the Me		NAVE	PHILL		COF		LEE		McDARIS		
2 shot and is m	19a. Informent's Name/Relationship (	**		. Mailing Addre	ss (Street end Nun	nber or Rurel Route No	umber, City or Town	n, Stete, Zip (	Code)		
Theal than	WILLIAM OPITZ(1  20a. Method of Disposition  1 → Burial 2 □ Cremation 3 □	BROTHER IN-	20b. Place o	4 SUGAR f Disposition (N ry, cremetory or	eme of	RT, APT. 10	20c. Location		, MD 21136 vn, State		
Demit. Pages Department of mportant: If its any injury or o	4 ☐ Donation 5 ☐ Other (Specif		GLEN	HAVEN M	EMORIAL I	PARK 9/3/98	GLEN B	URNIE,	MD.		
Permit Pe	21. Signature of Funeral Service Licer  23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications in 1 billused I one cause on Jach line		1 SEC	ode of dying, such	SINGLETO JE, S.W., O es cerdiac or respirato	ry arrest,	IE, MD			
Examiner	disease or condition resulting in death)			Secona consaquence of		aspiration	on	 	/ hrs.		
Represented virial-transit		0.	oue to (or as a	consequence of	·):						
lew requires that the death certificate beings as been signed by the attending physicians in 2 should be datached for use as the bunial applieded by Physician/Medical Expendical Expensions.		d	ue to (or es e	consequence of	):						
attendir for use	Death Other stands are delegated				and the state of the De	41 225	Did tehanan una a	antellanta ta	the sauce of death		
thet the death ce that by the attending detached for use y Physician/	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the undertying	cause given in Pa		23b. Did tobacco uae contribute to the call  1 Yes 2 No 3 Probably  24a. Was an eutopsy performed?  24b. Were euto available p completior of death?				
or Attanding Physician: The lew requires that after death after death by the funeral director, page 2 should be dettertification: To Be Completed by Piertification: To Be Completed by P											
The lew ate has pega 2							1□Yes 2⊅No		Yes 2□ No		
certificate rector, per							·	1	165 2010		
ysician: s certific director,	25. Wes cese referred to medical examiner?	Hospital:			Othor	ace of Death (Check o					
Physician: rthis certific ral director,	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatien		utpatient 3 0	JOA   4Ll	Nursing Home 5 ☐ I	Residence 6 ∐O nibe how Injury occu		)		
After fune	1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Dey	Year)	Injury M	28c. Injury et Work? 1 Yes 2						
tal or Attanding Pi rs after death. at Director: After the led in by the funera Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	e One Disease of faire	ry - At home, fa (Specify)			28f. Locati	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)				
3080	On Codding 45 0 miles on	yaician: To the best of	examinetion er	e, death occurre id/or investigation	d at the time, date on, in my opinion, o	end place, end due to leeth occurred at the ti	the cause(s) end n ime, dete end plece	nanner es sta e, end due to	ated. the ceuse(s)		
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he Hospi in 24 hou he Funer pletaly fill edical				2	-						
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To the Hospi within 24 hour To the Funer completely fill	29b. Signeture and title of certifier  Rogge 1  30. Neme end address of person who	and manner stet		(Type, Print)	-	844	August	30			

	4.5			21-98 WR.			Certificate of	Death	Data of I	Reg. No.		3. Time of Deeth
Physicia Medica	an	Secedent's Name	endolo,	_	Reede	x			2. Date of I	8/2 31	Year 1998	11.05 Am
Examine	4 4 4	Facility Name (If				1		0 11	or Location of De		y of Deeth	
Funeral Director		ocial Security No	umber 6	10000 10 M 2505	7. Age (In yrs	wter s. last birtho Yrs	Months Dave	r If Under 24	Vin. (Month,	n/a Birth Dey, Yeer) 8, 1922		place (Stete or Foreign ntry)
p a	-	al Residence of Stete	Decedent 10b. County		10c C	City, Town o	ar Location					0d. Inside City Limits
Aeryla f sho	. 30		n/	/a		ltimo						YYes 2□No
2 H ad	0 10	Street and Num		reet			10f. Zip Code 21211	W.		10g. Citizen of USA	Whet Cour	ntry?
020 urs after des al', or ftems	by Fur	Marital Status  1 □ Never Marrid  3 ☑ Widowed		d 1 ☐ Ye	ecedent Ever in 1 Forces? es 2 100 Give r Dates:	U,S. 1	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 以故	ban, Mexican, P	? (Specify Yes or uerto Rican, etc.)	Bi	ace - Americack, White,	etc.
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iryland 2 should be filled and Mental Hygie marked other matic event, to	<b>⊕</b> 17.	Eth Grad Father's Name ( Cank Ste	First, Middle, La	ast)					Name (First, Midd Tasker			
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Page mit if i	20a.	. Method of Disp 1 ☑ Barial 2 ☐ 4 ☐ Donetion	☐ Cremation 3				isposition (Neme of cremetory or other plane) Memorial		Sept. 4	20c. Location		
Balti permit. Departri Importa any inju		Signature of Fur	ust 9	7.4	Erry &		22. Name and Add	ns Falls		ltimore		
Physician /Medical		a. Part1. Enter the shock, or hear	ne disease, or on the failure. List or	omplications the nly one cause o	at caused the de on each line.	ath. Do not	enter the mode of dy	ving, such as ce	rdiac or respiratory	arrest,	1	Approximete
Examiner	disc	nediate Cause ( ease or condition ulting in death)		LYMPHO a. TO	4000	rdia	NVOLVING LUN					Interval Between Onset and Death 2 WEEKS
Model of the second of the sec	discress Caultrer Can Cauthair resident	ease or condition	nditions, imediate rhying injury	a. M	Due to	(or as a cor	INI					Onset and Death 2 WEEKS
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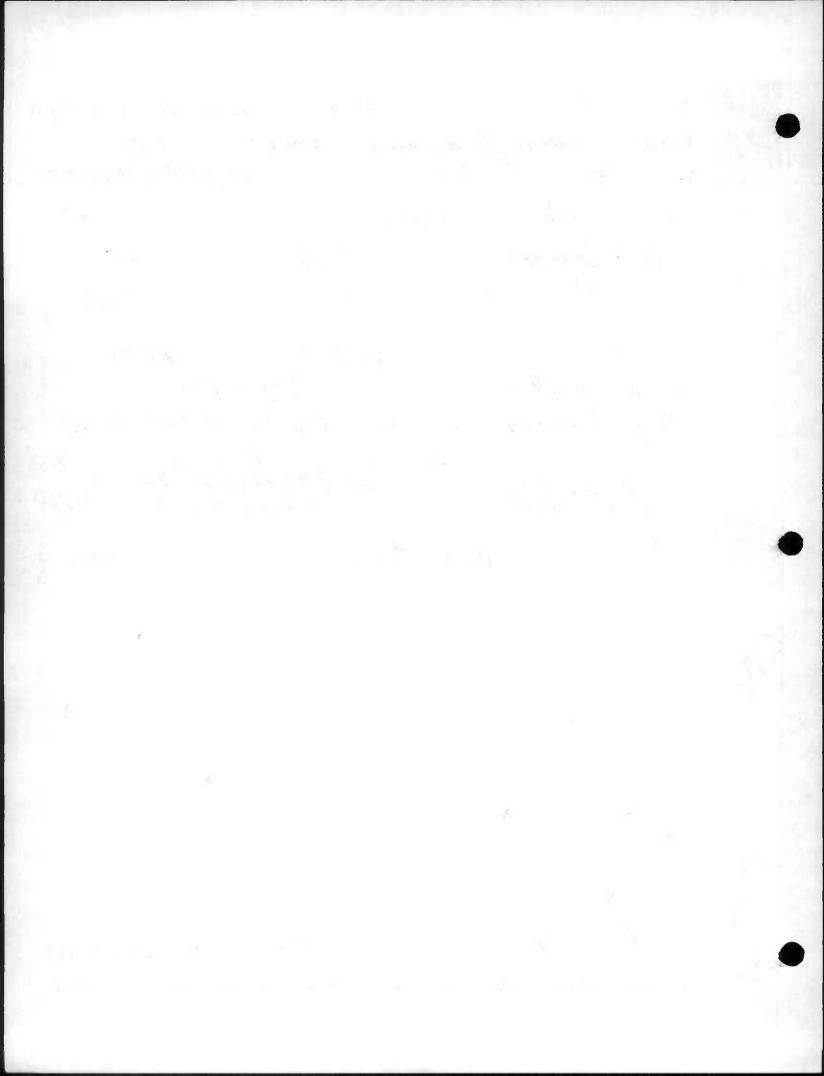


Amend: #23a Part Ia,b,Part II,29d Per MD State of Maryland / Department of Health and Mental Hygiene Film G763 9-2-98RC Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Deeth Month Yaer **Physician** AUGUST 25,1998 MARY STEPHENS /Medical 8:15A.M. 4e. Fecility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ridgeway Manor Baltimore N/A If Undar 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min. 8. Data of Birth (Month, Day, Year) 6-3-1912 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpleca (State or Foraign Country) **Funeral** Months 1 ☐ M 3 ☐ X F 230-16-3645 86 Yrs. Director N.C. Usuel Residence of Decedant with the Marylend 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MXYes 2□ No Directo Md N/A Baltimore 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 3014 Herbert Street 21216 USA Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Biack, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yas, Give Yeer or Detas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas X No Black þ Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent'e Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 2nd grade Coilege (1-4or 5+) Housewife Home Hygie is marked other permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hy important: If Nem Z7 is marked oth any injury or other traumatic event social. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) John Faulkner Katie Williams 2 19e. Informent'e Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Palmer V. Stephens-Son 6619 Windsor Mill Road Baltimore, Md 21207 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1) Buriel 2 Cremation 3 Removel from Steta Md Nat Memorial Park 4 □ Donetion 5 □ Other (Specify) 8-28-98 Laurel. Md 22 Nama and Address of Facility
March F/H West
4300 Wabash Avenue 21. Signetura of Funaral Service Licensee Glady Warne Baltimore, Md 21215 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feiture. List only one ceuse on each line. Approximata Intervei Between Onset end Deeth HYPOTENSION **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner CHRONIC RENAL FAILURE physician and s the bunel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or es a consequence of): ettending p signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown DIABETES MELLITUS þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? Completed peen 99 2 1 No this certificate 1 Tas 1 ☐ Yas 2 ☑ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 10 1 Yas 2 No 1 Inpatient 2 ER/Outpatlent 3 DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 5 Pending investigation 1 Neturei n 24 hours efter death.
he Funeral Director: Al
pletely filled in by the fu death. 1 TYes 2 TNo 2 Accidant 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and dua to tha causa(s) and menner es stated. To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of axeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and titla of certifie. 29c. Licanse number 29d. Data signed (Month, Day, Year) 9/2/98 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) GRAHAM. MAIDEN CHOICE-BALTOMD 21228 te filed (Month, Day, Year) SEP 0 2 1998 32. Régistrer's Signeture State Pener Registrar



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #29c Per Field Rep-DB Film G763 9-2-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Yeer **Physician** 7:15 AM SCURTO 1998 WILMA AUGUST 24 /Medical 4e Facility Neme (If not institution, give street and number 4h City Town or Location of Deeth 4c. County of Deeth Examiner BALTIMORE HOSPITALCENIER HARBOR If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6 Ser Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 1 E 212 28 3508 82 Director Oklahoma Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2K No Directo Maryland Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 300 Ridgely Road 21061 U.S. Funeral 14. Race - American Indien. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. Armed Folces: 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: ₩.₩. II 2 should be filed within 72 hours efter and Mental Hygiene. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 XNo Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Eiementery/Secondary (0-12) Teacher Elementary School 4 years 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) (not available) (not available) Porter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Ie n any Injury or other traun pace. Adriano Scurto / 112 Wallace Avenue Baltimore, Maryland 21225 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBuriai 2 ☐ Cremetion 3 ☐ Removei from State 8/27/98 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 pamerousk Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. Up only one cause on each line. Approximate intervei Between Onset end Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical C. O. P.D END STAGE 10 YEARS Examiner Due to (or es e consequenca of): Examiner D. SEYERE DEHYDRATION ONE WEEK physicien end s the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequença of): NUTRITION SECONDARY TWO WEEKS Physician/Medical Due to (or es e consequenca of): DYSPHAGIA USe 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No HEPA TI þ Records. 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed ARTERY DISEASE CORONARY 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 funeral 28d. Describe how Injury occurred 27. Menner of Deetl 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturei I or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a

within 2 To the

29c. License number P12090 DAUGUST

29d. Dete signed (Month, Day, Year)

1998

30. Neme end eddress of person who completed cause of death (item 23e) (Type, Print)

KASIBHOTLA 3001 S. HANDYERST BALTIMORE MD 21225 SUMABALA 31. Dete filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piaca, end due to the cause(s) end manner stated.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title a

32. Registrer's Signeture SEP 02 1998

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	1. Decedent's Name (First, Middle, L	ast)							2. Date of De		Veen	3. Time	of Deeth
hysician /Medical	THOMAS HARF	Y SUMME	RVILL	F					Month August	Day 23.	1998	17	47
iner	4a Facility Name (If not institution, g						4b. City, Tow	m, or Loc	ation of Deet		unty of Dee		1/
	Sinai Hospital	of Balti	more				Balti	more		1	N/A		
		Sex 7.	Age (In yrs.		Months	Days	If Under 2 Hours		B. Dete of Bir (Month, De		9 Bir	thplace (Stat	e or Foreig
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	Usual Residence of Decedent  10a. State 10b. County		100 C#	y, Town or	Location							10d. Inside	City Limit
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	MARYLAND N/A	4		BALI	IMORE					10- Ohina	of Minat C		
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I	3 Widowed 4 □ Divorced	If Yes, Give			1□ Yes	2 N/6	Specify:			Sp	ecity: BL	ACK	
	15. Decedent's I			16a. De	cedent's Usu	ual Occup	ation			16b. Kind	of Business		
I	(Specify only highest g	rade completed)	F. \	(G life	ive kind of we b. DO NOT u	ork done use retire	during most d)	of workin	g				
	11th grade	College (1-4d	or 5+)	SAN	ITATIO	ON				CLAY S	STANBO	ORN SAM	VIT.
	17. Father's Name (First, Middle, Las	st)					18. Mother	's Name	(First, Middle	Maiden Su	mame)		
	ARCHIE SUMMERVILL	.E					LED	IE B	OYD				
	19a. Informent's Name/Relationship	(Type, Print)		19b. M	ailing Addres	s (Street	and Number	or Rural	Route Numb	er, City or To	own, Stete,	Zip Code)	
	Onie Summerville	/Daughter	•	232	22 Dru	id Pa	ark Dr	ive,	Balti	more,	Maryl	and 23	1215
	20a. Method of Disposition			Plece of Dis	sposition (Na	ame of	ca)		Date	20c. Locat	tion - City or	Town, State	
Ì	XX Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec				VARY (			8	-27-98	BALTI	MORE	MARYL	AND
V	21. Signature of Funeral Service Lice	•			22. Name a	ind Addre	ss of Facility	,					
	1 Bode	K					WILL	IAM	C BROW NORTH			F/H F	.A.
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	c	Due to (d	or as a con	sequence of) sequenca of)	):						1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
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	25. Was case referred to medical examiner?	Hospital:				Oth	hor:		(Check only				
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-	1 PNatural 5 □ Pending	28a. Date of I (Month,	Day Year)	Injui	e of Ty M	28c. Injui	rk? IYes 2□N		ou. Describe	now injury o	ocurred.		
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	(Check only 2 Medical Exa	Phyaician: To the be aminer: On the basis and manner	s of examine										ie(s)
edical C	one)				29	9c. Licens	se number p	09292		29d. Dete s	signed (Mor	nth, Day, Yea	r)
	29b. Signature and title of certifier							07232					
edical		p no			A:	<del>3240.</del>	1321 KC	9914	-	August		1998	
completely filled in by the tuner  Medical Certification:		completed cause of	of death (Iter	n 23a) (Ty	1:	<del>3240.</del>	2321 KC	<del>9914</del>	-			1998	

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#### Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dev Month **Physician** AUGUST 31, 1998 8:00 Am 4a Facility Name (If not Institution, give street and number) D. STELLA /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner NIA 2413 FAIT Brutt more at Index 24 Hrs. B. Date of B. (Month, D. (Month, D. ) AUE 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6 Sex **Funeral** Months 100 M 20 F Davs 213-28-4060 MD Director DN. 4 1932 Usuel Residence of Decedent the Marylend 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County r 28a-f show 1⊟ Yes 2□ No Director MD. BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? r than "natural", or items 23a or the Medical Examiner must be USA 2413 FAIT AUG 21224 Funeral deeth 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status filed within 72 hours efter 1 □ Never Married 2 □ Married Specify: WHITE Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: p 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. CAN MANUFACTORY 10 TOW MOTOR OPERATOR NIA 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 12 should be fi ELIZABETH FEIRNSTEIN Dominic STELLA 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Papers 1 and 2 ment of Health e ant: If item 27 is ury or other tra 1409 MT. CARMEL KOBERT STELLA PARKITON 21/20 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) Date 20c. Location - City or Town, State 9/3/98 1 Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MALTO Mds SACRED HEAT OF JESUS 22. Name and Address of Fecility DELLA NOCE + SONS FUNERAL Home 21. Signature of Funeral Service Licensee 322 S. KICK ST. Brigo 2/202 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 6879 Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24a. Was an autopsy Completed After this certificete hes funeral director, pege 2 2 No 1 ☐ Yes 1 Yes 2 No Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certific 25. Was cese referred to medical examiner? 1 Yes 2 No Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 hour. the Funeral Directory 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number romors Lo 30. Name and eddress of person who completed gause of deeth (Item 23a) (Type, Print) St. Bul Suite 907 Baltimore MD 21202 301 Lync nomous

State Registrar 31. Date filed (Month, Dey, Year)

SEP 0 2 1998

32, Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician OZELL** 1998 WILLIAM THOMAS **AUGUST** 29 6:30 AM /Medical 4a. Facility Name (If not Institution, giva street end number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3720 ROAD BALTIMORE OVERVIEW If Under 1 Yeer 5. Sociel Security Number 6. Sex 1 M 2 ☐ F 7. Aga (In yrs. lest birthdey) Birthpleca (Stete or Foreign Country) **Funeral** Months Days 220-18-7856 70 Yrs. Director MARY LAND Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pagas 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Haelth and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Movical Exercises must be notified a police. 1X Yes 2 No Director MARULAND 10e. Street and Number 10g Citizen of Whet Country? 3720 KOAD OVERVIEW 14. Rece - American Indian, Biack, White, etc. Funeral 12. Wes Decedent Ever In U,S. Armed Forcas? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11. Maritel Stetus 1 XYes 2 No04-06-54 If Yes, Give Yeer or Dates: 01-28-54 1 Nevar Marriad 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced BLACK Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12++GRADE MECHANIC BALTO, CITY PUBLIC SCHOOLS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Sumama, Be HARRY BROWN P MABEL 19e. Informent's Name Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3720 OVERVIEW ROAD BALTIMORE, MD. 21215
ce of Disposition (Name of Dete 20c. Location - City or Town, Stete ODELL THOMAS (WIFE Baltimore, 20e. Method of Disposition 1 K Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) GARRISON FOREST CEME 9-03-98 CWINGS MILLS, MD. 21. Signature of Funeral Service Licenses JOSEPHO A. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVENUE, BALTIMORE, MD. 21217 23e. Paul L. Enter the disease, or complications that causad the deeth. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, sheek, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Finel diseese or condition resulting In death) /Medicai NON SMALL CELL CARCINOMA OF THE LUNG Examiner Dua to (or es e consequence of) Examiner hysician end ha burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es a consequence of) 68760. niysician Physician/Medical Due to (or es e consequence of) Hospital or Attending Physician: The law requires that the destit shours after death.

Funeral Director: After this cartificate has been signed by the arter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? Yes 2 No 3 Probably 4 Unknown STROKE à 24b. Ware eutopsy findings evelleble prior to completion of causa of deeth? Completed 24e. Wes en eutopsy performed? COR PULMONNIE CHRANCOBSTAUCTIVE LUM DISENSE 1 ☐ Yes 2 No 1 🗆 Yes 25. Wes case referred to medical exeminar? Be 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident To the Hospital or Atter within 24 hours after des To the Funeral Director complately filled in by th 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier Medical 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and dua to tha cause(s) and manner as steted. 2 Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and-title of g 29c. License number 29d. Dete signed (Month, Dey, Year) 8-31-98 D50086 30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) JEFFRE) WETSTONE MO 7141 Security BluD BALTIMORE MD 21244 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State SEP 0 2 1998 Registrar

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 11:10 PM **Physician** attie Month /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Battimore Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□ M 2□F Deys 217-18-355 Usuel Residence of Decedent Yrs. Director 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits Ballmore 19 Tes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21205 U.S.A. 2106 Vetterson Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ 10 If Yes, Give Year or Detes; 14. Race - American Indian, Black, White, etc. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Black 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry JOB DESCRIPTS USUAL DECUPATION (Give kind of work done during most of working life. DO NOT use retired) Super-Visor Dietary Aide Elementary/Secondary (0-12) College (1-4or 5+) grade 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Robert-50N Lee Howard 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4710 Furley Ark, Batto 2MD 2120 Furley Ark, Lee Tammie 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Surlat 2 □ Cremation 3 □ Removal from State Bathmore, 4 ☐ Donetlon 5 ☐ Other (Specify) Cometery of Funeral Service Licensee 22. Name end Address of Facility 1101 EAST March Part1. Enter the disease, or conclications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical immediate Cause (Final Hepatocellular Carcinoma disease or condition resulting in death) Examiner Kenal Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of) Spiralio Due to (or es e consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of afaith? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were eutopsy findings availeble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ₺ No 1 Yes 2 18 No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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after

RIME

Baltimore, Maryland 21215-0020

the Medical Examiner

29a. Certifier

29b. Signature end title of certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

ille THE MD

29c. License number

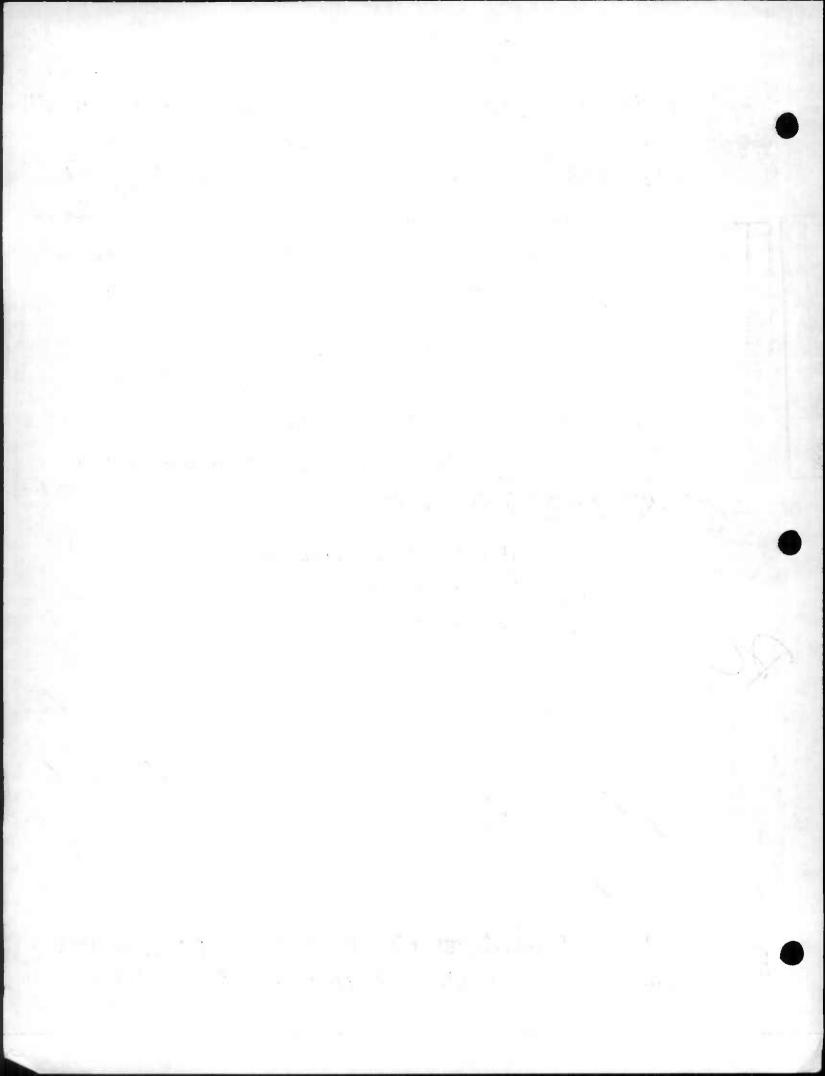
29d. Date signed (Month, Dey, Year) August 28, 1998

30. Home and address of person who completed cause of death (Item 230) (Type, Print)

Servae F Wicks TE N.D. 100 North Broadway servae t. 31. Date filed (Month, Dey, Year) SEP 0 2 1998

State Registrar

32. Registrar's Signeture

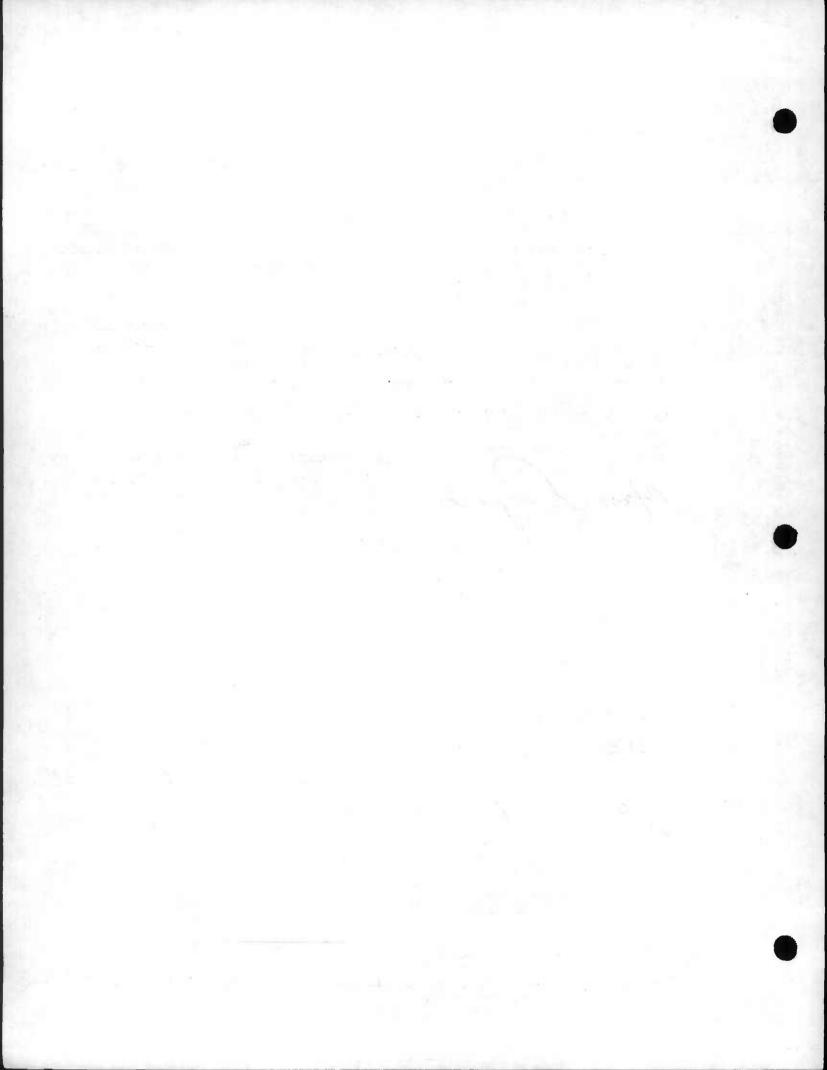


# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of Death		Reg. No.	20038	
	1. Decedent's Name (First, Middle, Las	· ·			2. Dete of I	Deeth Day	3. Time of Deeth	
Physician /Medical	James J Tu	bens			08	31	98 03:15	
Examiner	4a Facility Name (If not Institution, give				wn, or Location of De	ath 4c. County	of Death	
	UNIVERSITY OF	MARYLAND ME	DICAL CENT	The BALT	IM WZE	N/A		
Funeral Director	5. Sociel Security Number 6. S 103–28–9632 1 Usuel Residence of Decedent	PX 7. Age (In yrs. X M 2 F 61	lest birthday) If Und Months	er 1 Year If Under B Deys Hours	Min. (Month, I		9. Birthplece (State or Foreign Country) New York	
Maryland I show	10e. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits	
\$ 85 B	Maryland Baltimo	re Co (	Owings Mil	S ip Code		10g. Citizen of V	1 ∑ Yes 2 □ No	
23a or	6 Nobility Cou	rt (Apt D)		21117		U,S.A		
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Magage Ma	Wendy R. Blum (1	Friend)	6 Nobili	ty Court.	Apt D. Ow	ings Mill	Ls, Md 21117	
Baltimore, semit. Pages 1 a Separtment of His mportant: if Isen iny Injury or othe ince.	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Plece of Disposition (Notemetery, cremetery or	ame of other piece)	Date	20c. Location -	City or Town, State	
The state of the s	21. Signature of Funeral Service Licen			emetery and Address of Fecili		Baltimon	re, Maryland	
Balt permit Depart Import any inj anse	1 a alan	Seit In	A, A	lan Seitz	Jr. Fune	ral Home	Maryland 21211	
Physician	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one ceuse off each line.	h. Do not enter the me	ode of dying, such es	cardiac or respiretory	arrest,	Approximate Intervel Between Onset end Death	
/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	· Multiples	ystem orga	n failure			1 month 37 days 6 years	
je le		Due to (c	or es e consequence o	):			371	
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cal Ex	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. Primary p	ulmonary	fibrosis			Cypars	
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f Vital Re yeldan: The le s certificata ha director, paga	25. Wes case referred to medical examiner?			26. Place	of Deeth (Check only	y one)		
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ion o	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work?		e how injury occurr	red	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At he building, etc. (Specification)	ome, farm, street, fectory)	ry, office		(Street end Numb own, Stete)	er or Rurel Route Number,	
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Ne the	29b. Signature and title of certifier		2	9c. License number		29d. Date signed	d (Month, Day, Year)	
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071	30. Name and address of person who of BRET BORCAET	ompleted cause of deeth (Item	1 23e) (Type, Print) S. GREEU	E ST BI	ALTIMORE,	MD ZIZ	0/	
State Registrar	31. Dete filed (Month, Day, Year) SEP 0 2 19	32. Registrer's Signe		land,				

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Amend: #29c Per Field Rep-DB Film G763 9-2-98RC Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death Physician TROUTMAN WILLIAM AUGUST 29 1998 6:16a /Medical 4a Facility Nama (ff not institution, give street and number)
THE JOHNS HOPKINS HOSPITAL 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth April 1 Pay, Sear) 16 7. Aga (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Pennsylvania 186-09-1439 1(XM 2□ F 82 Vrs Director Usual Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d Inside City Limits ma 23a or 28a-f ahow must be notified at 1¥1 Yas 2 □ No Director PA Dauphin Millersburg 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 740 Church Street 17061 U.S. of America Funeral death 12. Was Decedent Evar in U.S. Armed Forcas? 1942 – 12 Yes 2 □ No If Yas, Giva Year or Datas: Home : 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 72 hours after 1 Nevar Married 2 Married "netural", or h altimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Automobile 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filled within 7 nent of Health and Mental Hyglene. ant: if Item 27 le marked other than "nury or other traumatic event, the Medury or other traumatic event, the Med Elementary/Secondary (0-12) Collega (1-4or 5+) Dealership 8 Automobile Dealer 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Albert W. Troutman Shoop 0 Dora 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 Church St. Millersburg, PA. 17061 Dorothy T. Troutman(Wife) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata ↑ Burial 2 Cramation 3 Ramoval from Stata Sept. permit. Page Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Cemetery Millersburg, PA. <sup>22. Name and Address of Facility</sup>
W. Dabrowski-Chojnacki F.H. 's P.A.
1005 Dundalk Ave. Balto., Md.21224 21. Signature of Funeral Service Licen: that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, son each line. Approximate Interval Between Onset and Death Physician Immediata Causa (Final disease or condition rasulting in death) /Medical 2 HOURS Examiner Dua to (or as a consequanca of) Examiner P215 10 DAYS physician and the burial-transit or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): for usa signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 X Unknown 1 ☐ Yes 2 ☐ No MITRAL REGULITATION Records, þ 24b. Wera autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? HIPERBILIRUSINEMIA 2 NO 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was casa referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation ne Hospital or Attending in 24 hours efter deeth. The Funeral Director: After pletely filled in by the fur 1 □ Yas 2 □ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29b. Signatura and title of certifier 29d. Data signed (Month, Day, Year) P11592 ANDREW SINGER M.I 30. Nama and addrass of parson who completed cause of death (Item 23a) (Type, Print) STNOCK, SOANS HOPKINS HOSPITAL, BACTMONE, MARVIND 31. Data filed (Month, Day, Year) SEP 2 1998 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend: #16a,b Per FH Film G763 9-2-98RC State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Mogth **Physician** 3:09 Ry 1 NCE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number, Examiner Baltimore Hopkins Hospita John If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number (In yrs. last birthday) inthplece (State or Foreign **Funeral** 10M 2DF Months 216-60-591 Usual Residence of Decedent 56 Yrs. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified at with the Maryle 1 Ves 2 No Himore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21213 U.S. 2 esterkield death Funeral Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any Injury or other traumetic event, the Medical Examples. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1□ Yes 2DNo altimore, Maryland 21215-0020 Specify à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unk. Unk. 18. Mother's Name (First, Middle, Meiden Sumeme) 17, Fether's Neme (First, Middle, Last) Be incelo OSE 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) . Balto. Chesterfield 111 Md. 21213 ve 20b. Place of Disposition (Name of carretery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State Zion 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility iller P.C. Runeral home Service 1639 road 700 Entire the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, all failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final disease or condition resulting in death) Disease - Cardiac Arrest Examiner Due to (or es a consequence of) Examiner me habetes Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) Hypertension Physician/Medical Due to (or es e consequenca of) Peripheral ascular disease 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No obacco Abuse 2 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed Stroke 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Inpatient 2 ER/Outpetient 3 DOA funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Natural
2 Accident To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one)

29c. License number

E. Oliver St. Baltimore, MD 21213

29d. Date signed (Month, Dey, Year)

State Registrar

29b. Signeture end title of certifier

Edith

30. Neme end eddress of person who completed cause of fleath (Item 23a) (Type, Print)

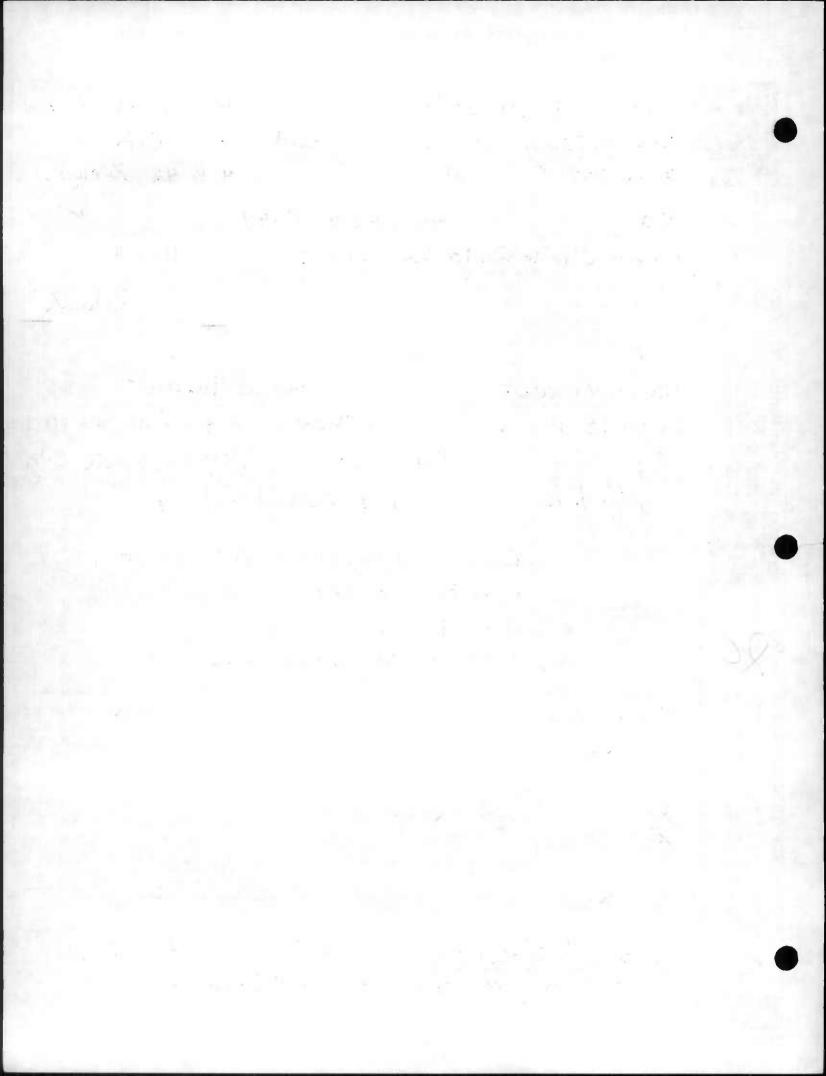
SAD

32. Registrer's Signeture

2900

Vargo

Вох 68760



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Deeth **Physician** Josef Vaselkiv 30 1998 5:55PM August /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner 201 Crickett Ct. Baltimore Timonium 5. Social Security Number 7. Aga (in yrs. last birthday) If Undar 1 Yaar 8. Data of Birth Novembre, Day, Years 08 9. Birthplaca (State or Foreign Country) Pennsylvania 6 Sax **Funeral** 1 M 2 □ F Months Days Hours Min. 068-09-9464 Yrs. **Director** Usual Rasidance of Decedant filed within 72 hours after death with the Marylend 10a Stata 10b County 10c. City. Town or Location 10d. Insida City Limits ahow re 23a or 28a-f aho 1 ☐ Yas 2 No Baltimore Timonium MD. Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Counfry? 201 Crickett Ct. 21093 USA Funeral r than "natural", or items 12. Was Decedant Evar in U,S. Armad Forcas? 1∑ Yas 2 □ No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, 11. Marital Status Was Dacedanf of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 WWII 1 ☐ Yas 2 ☒ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedanfs Education (Specify only highast grade completed) Collega (1-4or 5+) Elamantary/Secondary (0-12) Hygiane. Chef Restaurant 7 is marked other traumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mofhar's Nama (First, Middla, Maidan Sumama) Peges 1 end 2 should be filt fraent of Health end Mentel H tant: If Itam 27 is marked oth jury or other traumatic even Be Marussia Diakun Wasylkiw Ivan 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 201 Crickett Ct. Timonium, MD. 21093 19a. Informant's Name/Ralationship (Type, Print)
Mrs. Nadia Vaselkiv/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Ramoval from State permit. Pege Department of Important: If any Injury or once. 9-2-98 South Abington, PA. Abington Hills Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signatura of Funaral Sarvice License Inc. 21204 23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaan Onsat and Death **Physician** /ivicaica Immediata Causa (Final Myledysplana disaasa or condition resulting in daath) Examine Dua to (or as a consequance of) Physician/Medical Examiner physician end the burial-transit Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Causa (Disaase or Injury that initiated evants rasulting in death) Lasf Dua fo (or as a consequence of): Records, P.O. Box 68760 Dua to (or as a consequanca of) requires that the death certificete attanding pl signad by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings availabla prior to completion of ceusa of death? been si Completed 24a. Was an autopsy parformad' s certificate hes b director, paga 2 s 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: director, 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Check only ona) Be Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yes 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Manner of Daath 28b. Tima of 28c. Injury at Work? After 1. Natural
2 Accidant Attending 5 Panding or Attendination after death. 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, straat, factory, office building, etc. (Specity) 3 4 Homicide filled in Hospital 24 hours a 24 hours Funeral Certifying Physician: To the best of my knowledge, daeth occurred et the time, dete end plece, and due to tha causa(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner estated. 29a. Cartifiar edical stely (Check only one) To the I Within 2 To the I Allerda 29d. Data signad (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifiar 8/31/98 C.M. word but 30. Nama and addrass of person who completed cause of death (Itam 23a) (Type, Print) N. Chanles St, Sulte 200 Ball more O.M. STEWAJOSIAZ MISASW 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State 3cpers SEP 0 2 1998 parks Registrar

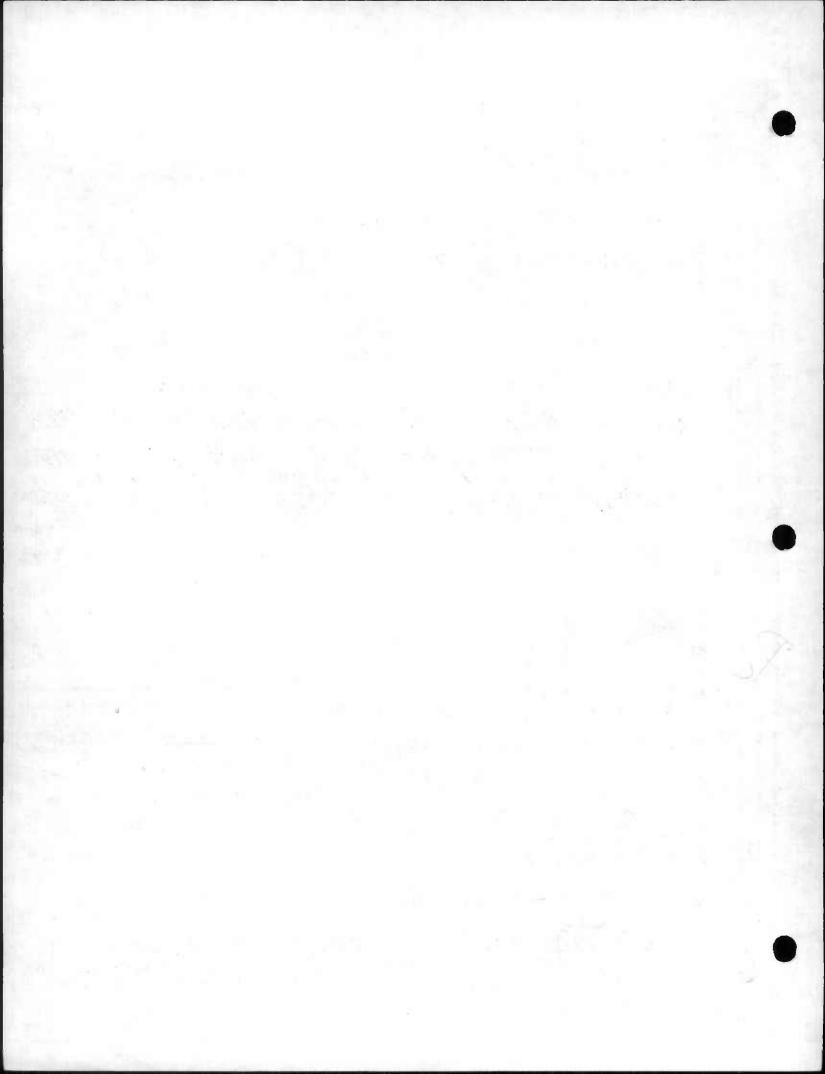
State of Maryland / Department of Health and Mental Hygiene

		4 Decederal News (First M	idata danah			Ce	rtificate or	Death			eg. No.	4	6842
Physi		1. Decedent's Neme (First, M. Elsie E. W.								2. Dete of Deer Month September	Dev	8 <sup>Year</sup>	3. Time of Deeth 9:50an
/Med Exam		4a. Fecility Neme (If not institu Fallston Gene						4b. City, Tow Fall	n, or Loc	ation of Death	4c. County		ford
Funera Directo		5. Social Security Number 325–07–7962	6. Sex 1 ☐ M <b>2</b>		(in yrs. lest t	birthdey) Yrs.	If Under 1 Yea Months Dey	r If Under 2	4 Hrs.	B. Dete of Birth (Month, Dey	Year) 28, 1896	9. Birthp	lece (Stete or Foreign try)
Maryland -f show	tor	Usuel Residence of Decedent 10a. Stete 10b. Cou			10c. City, To Belai		ocation aryland					1	0d. Inside City Limits
h with the 13a or 28a at be not	Funeral Director	10e. Street end Number 413 Lynwood Avenue					10f. Zip Code	014	П	10g. Citizen of Whet Co United St			
020 nurs after deal all, or items 3	by	11. Maritel Stetus  1 Never Married 2 N	Armed 1 7 If Yes	Decedent Ed Forces? es ZZNN , Give or Detes:			Was Decedent of If Yes, specify Cu		in? (Spec Puerto R	ify Yes or No- ican, etc.)		e - Americ ck, White, w: Wh:	
Z1Z15-UUZU d within 72 hours at giene. or then "natural", or , the Wool cal Exert.	Completed	(Specify only hig Elementery/Secondary (0-1		e (1-4or 5		(Give	dent's Usuei Occi kind of work don DO NOT use retir	e during most ( ed)	of working	7	16b. Kind of Bu		
yland 212: ould be filed within Mental Hygiene. erked other then	To Be Co	8th Grade 17. Fether's Neme (First, Midd Herman Zierv				H	omemaker	18. Mother	's Neme (	First, Middle, I	Maiden Sumen		Home
Mar nd 2 sh lith and 27 is m	-	19e. Informent's Neme/Releti Virginia Otto			15		ng Address (Stree Lynwood						
Baltimore, I permit. Pages 1 and Department of Healt Important: if item 21 any injury or other.		20e. Method of Disposition  1 Burial 2 Cremetic  4 Donetion 5 Other	(Specify)		Chapel	Hill	esition (Neme of metory or other pi L West Cem	etery		5, 1998	20c. Location - Dakbrook	Terra	
Deamit. Departi		21. Signature of Funerel Serv	icaulcansee Vic	tor P.	Doda, Ji	Ch 15	2. Name end Add arles L. 01 East	Steve Fort A	ns F venu	uneral e, Balt	Home,	Inc. Maryl	and 21230
Physiciar /Medica Examine		23a. Pent1. Enter the disease shock, or heart feilure. I Immediate Cause (Final disease or condition resulting in death)		lent		ol	ardiu)				est,		Approximete Intervel Between Onset end Deeth
mpt character as associed	n/Medical Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiesed events resulting in deeth) Lest	d		Due to (or es e								
y the da	Physician/M	Pert II. Other significant cond	in the u	nderlying cause ç	iven in Pert I.		23b. Did to		ntribute to	the cause of death			
beer should	Completed by									24a. Wes e	n eutopsy ned?	COL	ere eutopsy findings eilable prior to mpletion of cause deeth?
ysician: The lav ysician: The lav is certificate has director, page 2	Be Co	25. Wes case referred to med exeminer?	ical					26. Place	of Deeth	1 TY		10	Yes 2 No
VISION OF VITA Attending Physician: or death. betor: After this certific by the funeral director,	10	1 Yes 2 No  27. Menner of Deeth  1 Naturel 5 Per 2 Accident	ding (N	itel: Other:			rsing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			y)			
To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the 1	Certification:	4 ☐ Homicide dete	bu	uilding, etc.	(Specify)		reet, fectory, office			City or Town	n, Stete)		l Route Number,
To the Hospital or / within 24 hours after To the Funeral Director Completely filled in the comp	edicai	29a. Certifier 1 2 Certifier (Check only one)	ying Physicien: To eal Examiner: On the end m	the best of e basis of e nanner stet	examinetion e	ge, deeth and/or inv	occurred et the vestigetion, in my	time, dete end opinion, deeth	piece, en occurred	d due to the ca d et the time, d	ause(s) end me ate end plece,	enner as st end due to	ated. the cause(s)
To the To the Comp	M	29b. Signeture and title of cert	fier /	D				3 46 5	2	\frac{2}{5}	9d. Dete signe	d (Month, i	Dey, Year)
3		30. Name and address of pers	on who completed of	ause of de	eth (item 23e	Type,	Print) AVIN	ne B	11	Air /	Many la	nd	, 199r 21014
S: Regis	tate trar	31. Dete filed (Month, Day, Ye SEP 0 2 19		2. Registre	's Signeture		boards	,			,		1

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9

		Certifica	te of Death		g. No. 98 2	6843
Physician /Medical			natley	2. Date of Death Month August	30,1998	CONTRACTOR STATE OF THE PARTY O
Examiner	4a Facility Name (If not institution, give street and numb THE JOHNS HOPKINS HOSPIT		4b. City, Town, or BALTIMORE		4c. County of Dept	
Funeral Director		Age (In yrs. last birthday) If Und	er 1 Year   If Under 24 Hrs. s Days Hours Min.		9. Birt	holace (State or Foreign untry)
Maryland a-f show filed.at	10a, State 10b, County	10c. City, Town or Location	25			10d. Inside City Limits 1 EHYes 2 □ No
iter death with the Ma r Harrs 23e or 28e-f s niner must be notifies Funeral Director	10e. Street and Number 830 WINDWOOD 3	Policy 101.2	21229	10	g. Citizen of What Co	untry?
by Exe	3 ☐ Widowed 4 ☐ Divorced Year or Date	⊡•No / 1□ Yes	dent of Hispanic Origin? (Secify Cuban, Mexican, Puerl 2019 Specify:	pecify Yes or No- o Rican, etc.)	14. Hace - Ame Black, White Specify: Bu	
uid be filed within 72 ho Mental Hygiens. Had other than "naturi fits event, the Medical." To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4)	life DQ NOT	ual Occupation work done during most of work done during most of worker to the most of work of the market of the m	king	50. Kind of Business	Industry
Mental Hyg Mental Hyg rivad other file event, I	17. Father's Name (First, Middle, Last)	(107)	18. Motheca Nar	ne (First, Middle, M.	aiden Surname)	
and 2 sho ealth and 1 n 27 is me her traume	AV QUINTITE H. THAN	MGS 381/7	ea (Street and Number or Fit	Also, 9	BALTIM	D. 21229
ment of H tant: If her jury or off	20a. Methylo-of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from St.  4 □ Donation 9 □ Other (Specify)	HUMAN !	APRK	9/3/98 9	oc. Location - City or	Town, State
Depar Impor	21. Signature of Pugeral Service Licensee	25	TRED ALL	HEMES FON TO	A/ADME	NO. 21229
hysician /Medical	23a. Party Euler the opease, or complications that caushook, or heart failure. List only one cause on each	cerebral	100		44.	Approximate Interval Between Onset and Death
Examiner E	disease or condition resulting in deeth)	Due to (or as a consequence or			l I	11 days
Muta-transit	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es e consequence of	i):		1	
ding pleased	thet initialed events resulting in death) Lest	Due to (or es a consequence of	):		1	
the shed shed shed shed shed shed shed sh	Pert If. Other significant conditions contributing to deat	th but not resulting in the underlying	cause given in Pert I.	23b. Did tob	ecco use contribute	to the cause of death?
een signed by the hould be detached	bacteremia, St	tatus post	thoraco-	1 Ye	2 20No 3□P	robably 4 Unknown
200	abdominal aneury	sm repair		24a. Was an perform	ed?	Were autopsy findings eveilable prior to completion of cause of death?
certificate has rector, page 2				1 ☐ Yes		1   Yes 2000
this certific ral director, To Be	25. Wes case referred to medical examiner?	patient 2 ER/Outpatient 3 I	Other	oth <i>(Check only one</i> lome 5 ☐ Resider	nce 6 Other (Spe	cify)
o se se se se se se se se se se se se se	27. Menner of Deeth  Neturel 5 Pending  Accident Investigation  28e. Date of (Month,		28c. Injury at Work? 1 Yes 2 No	28d. Describe how		,
within 24 hours after death, To the Funeral Director, After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide 28e. Plece of building	I Injury - At home, ferm, street, fector, etc. (Specify)	ory, office	28f. Location (Str. City or Town,	eet and Number or Ru Stete)	ural Route Number,
24 hou 24 hou Frund etely fi.	29a. Certifier (Check only one)  Certifying Physician: To the basi end mennel	is of examinetion and/or investigation	d et the time, date end place on, in my opinion, death occu	, and due to the car pried at the time, da	use(s) and menner es te end place, end due	stated. to the cause(s)
within To the comple	29b. Signature and title of certifier		9c. License number	29	d. Date signed (Mont	h, Day, Year)
1	mi mi		050437	MD A	ugust 3	10.1998
6	30. Neme and address of person who completed cause	of deeth (Item 23a) (Type, Print)	00 01 4		+ Balt	imore, mo
		ov MD (a	00 North W	olte Stre	el	21287
State Registrar	SEP 0 2 1998 Siene	J. Ann	1			

DHMH 16 Rev 6/95



#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death NORMAN WOBBEKING 6:30 p AUGUST 31,1998 4a Facility Nama (If not institution, giva straet and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY tf Under 1 Year If Under 24 Hrs. 8. Date o 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Dev. Year) Hours Min. 7 M 2□ F Months Days 215-16-0556 76 Yrs. Maryland Usual Residence of Decedent 10a. Stata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Md. 1 ☐ Yes 2 ☐ No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 568 Whispering Meadows Dr. 21157 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Marriad 1 Nas 2 No If Yes, Give Year or Dates: WW II 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Computer Dept. Supervisor 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Clara Marie Schlaffer Adolph G. Wobbeking 19e. Informent's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 4405 Hillside Ave., Baltimore, Md. 21229 Charles A. Wobbeking 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Specify) Millers Church Cem. Sept. 4, 1998 Millers, Maryland 22. Name and Address of Facility Eckhardt Funeral Chapel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximately a specific control of the con Approximate Interval Betwaen Onset end Deeth Immediate Cause (Final disaase or condition resulting in deeth) ERPSIS Infection wand Due to (or as e consequenca of) Dua to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Brain 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 🙎 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funerai

by

Completed

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 2 and in highly or other traumatic event, the Medical Examination must be not once.

Saltimore, Maryland 21215-0020

page 2 s

or Attending Physician: funeral director, After this efter death. 24 hours Hospital within 2

Division of Vital Records, P.O. Box 68760

Registrar

29b. Signature and title of certifier

Div. Year)

0 2 1998

30. Name and address

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in daath) Last Physician/Medical Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed 25. Was case referred to medical examiner? Be Hospital: ► Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Restdence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es stated. edical 29a. Certified 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only

29c. Licansa number

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who completed cause of death (Item 23a) (Type, Print)

M.O.

32. Registrar's Signature

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29d. Date signed (Month, Day, Year)

Baltimore, MO 21287

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend: #29c Per Field Rep-DB Film G763 9-2-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day 29 **Physician** WILLIE YFLLORDY 1998 :55 AM August /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner BALTIMORE SINAI HOSPITAL If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Days 100M 20F Months Yrs North Carolina 70 Director 11/29/1927 246-30-9712 Usual Residence of Deceden with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shot traumatic event, its Modical Examinar must be notified at 1 X Yes 2 □ No Directo Maryland Baltimore 10f. Zip Code 10g. Cifizen of What Country? 10e. Sfreet and Numbe U.S.A. 21215 Funeral 3627 Oakmont Avenue filed within 72 hours after death 12. Wes Decedent Ever in U,S. Armed Forces? 1√7,Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Merried Specify: Black Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiane. Elementary/Secondary (0-12) College (1-4or 5+) Maintenence Engineer 10 Coppin College 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 is marked othe any injury or other traumatic event pixes. Annie Purnell Ed Yellordy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3627 Oakmont Ave., Baltimore, Maryland 21215 Bridgette Edwards/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Va Cem. 09/03/980wings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Derrick C. Jones Funeral Hm. 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Pert1. Enfer the disease, or complications fine ceused the deeth. Do not enfer the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . ANEMIA Examiner Due to (or es e consequence of): Examiner PANCREATIC AND LIVER ADENOCARCINOMA Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 6876 Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? signed by t 1 Yes 2 No 3 Probably 4 Unknown ESOPHAGEAL VARICES Division of Vital Records. A 24b. Were autopsy findings available prior to completion of ceuse of death? should 24a. Was an autopsy Completed The law has page 1 Yes 2 No 1 Yes 2 No this certificate septal or Attending Physician: Thous after death.

neral Director: After this certificat
y filled in by the funeral director, pa Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 28c. Injury et Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Phyalclan: To the best of my knowledge, death occurred et the time, date end plece, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifler completely

FOTIS

31. Date filed (Month, Day, Year) STEPHEN, M.O.
ar) 32. Registrer's Signature

29b. Signature and fitte of certifier

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29d. Date signed (Month, Dey, Year) 30,1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

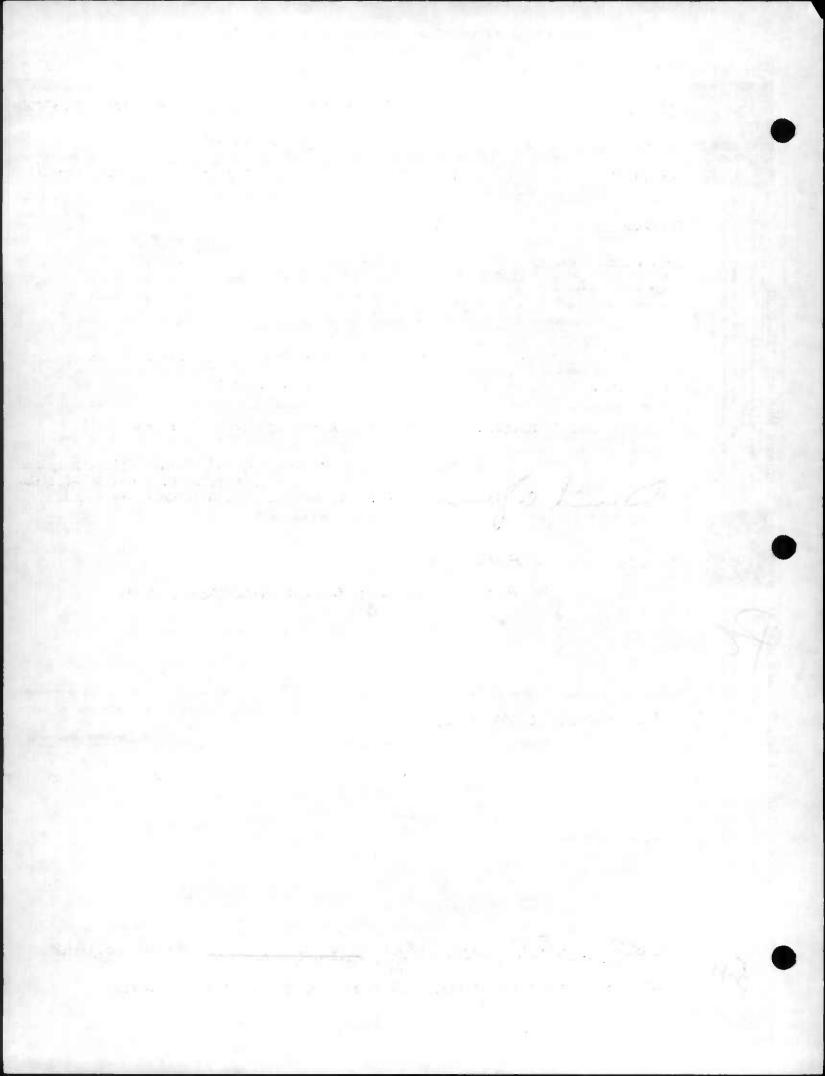
SINAL MOSPITAL OF BALTIMORE

29c. License number P12340

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Registrar **DHMH 16 Rev 6/95** 

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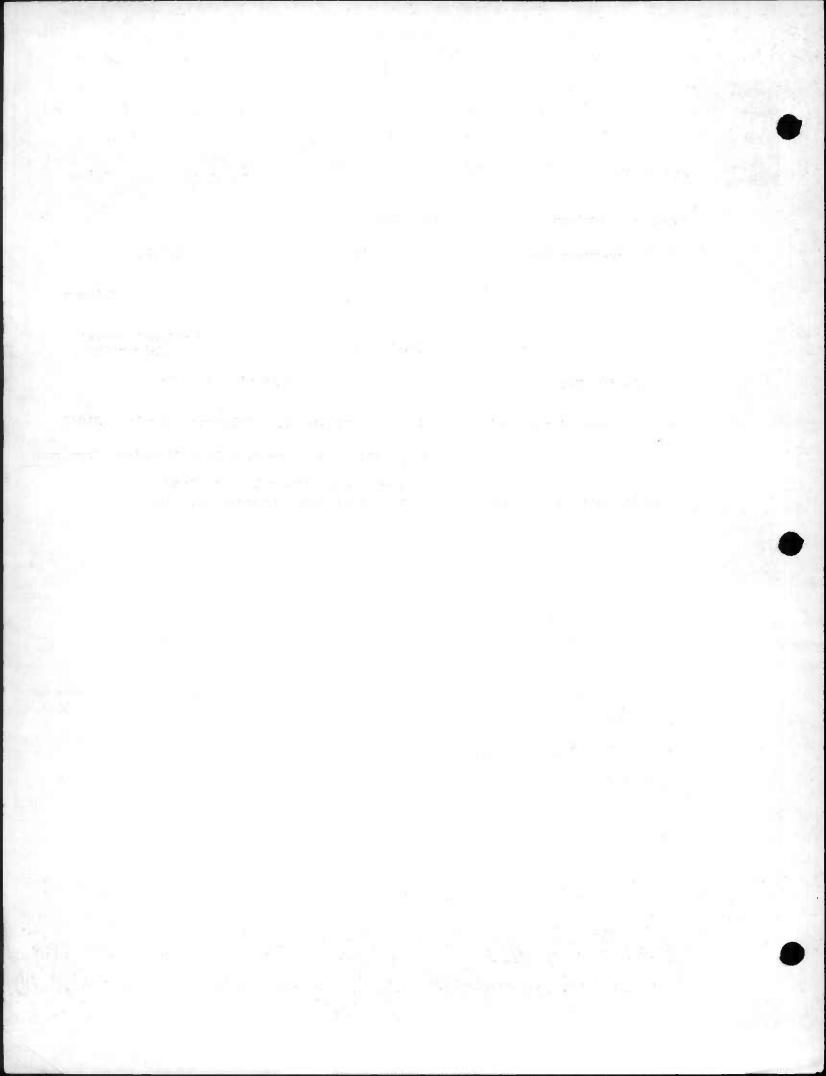


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						Certificate of		Reg.	20	20046
	Physici /Medi	cal	Decedent's Name (First, Middle, Las	L YAC	)		4b. City, Town, or Lo	2. Dete of Death Month August	Dey Y	3. Time of Deeth 998 0921
	Examir Funeral Director	ner	The John 6. Se 5. Social Sacurity Number 6. Se	JOPKINS E	RCIATOR yrs. last birtho	Center   (ay) If Undar 1 Yaar   Months   Days	0 1	8. Date of Birth (Month, Dey, Ye	Balt	Deeth  MOFE  D. Birthplace (State or Foreign Country)  China
٦	and		Usuel Residenca of Decedent  10a. State 10b. County	10	c. City, Town o	r Location				10d. Insida City Limits
	Maryi a-f sho	tor	Maryland Harford		Fall					1 ☐ Yes 2 🛣 No
	ath with the	ral Director	10e. Street end Numbar 2205 Watervale F	Road		10f. Zip Code 21047			Citizen of Wh	et Country?
020	urs efter de al', or Items	by Funeral	11. Maritel Status  1 Nevar Married 2 Married  3 Widowed 4 Divorcad	12. Was Dacedent Ever Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Yeer or Detes:	r in U,S.	13. Was Decedent of H If Yas, specify Cub 1 ☐ Yes 2 X No		cify Yas or No- Rican, etc.)	Amarican Indien, White, etc. Chinese	
21215-0020	d 2 should be filed within 72 hours efter death with the Maryland the and Mental Hyglene. 7 Is marked other than "netural", or items 23a or 28a-f show traumatic event, the Medical Event in must be not find at	Completed	15. Decedent's Edi (Specify only highest gred Elementery/Secondary (0-12)	completed)	(G	ecedent's Usuel Occup live kind of work done re. DO NOT use retire Ofessor	pation <i>during</i> most of workin d)	na		ness/industry Normal ersity
Maryland 2	ould be filed Mental Hyg arkad other atic event,	To Be C	17. Fether's Neme (First, Middle, Last) Chi-Lin Yao				18. Mothar's Nama Shao		den Sumema) Yao	
Many	2 should end Men is marka		19a. Informent's Name/Reletionship (T			leiling Addrass (Straet				
Baltimore, A	teal Heal		Mrs Karen Wong (Da  20e. Method of Disposition  Burial 2 Cremetion 3 4 Donation 5 Other (Specify,	Removel from State	20b. Placa of D	05 Waterva isposition (Neme of cremetory or other ple y Valley M	ce)	Date 200	. Location - Ci	and 21047 ty or Town, Stete um, Maryland
Balti	permit. Peges 'Depertment of H Important: If Ite any injury or of once,		21. Signature of Funeral Service Licans  Wallace S		0.4	22. Name and Addre Ruck Towso 1050 York				
	Physician /Medical Examiner	Iner	23e. Pert1. Enter the disease, or comp shock, or heert failure. List only o Immediate Ceuse (Finel disease or condition resulting in deeth)	a PNEUM			ng, saar 63 cardiac 0	respiratory direct,	<	Approximate Interval Between Onset end Deeth
Box 68760,	leath certificate barreuted attending physician and for use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest	c	to (or es e con					
	death he atte	Physician/M	Pert II. Other significant conditions co	ntributing to death but no	ot resulting in th	e underlying cause giv	ven in Pert I.	23b. Did tobe	cco use contr	ibute to the cause of deeth?
ls, P.O	law requires that the death cert es been signed by the attendin o 2 should be deteched for use	by	Stroke					1 Tes	2□ No 3	Probably 4 Unknown
Records,	The law require ate hes been signage 2 should to	Completed	PARKINSONS	DISEA	SE			24a. Was an a performed		24b. Were autopsy findings eveileble prior to completion of cause of deeth?
Vital F	lcian: The l certificate horsector, page		25. Wes case referred to medical					1 ☐ Yes	2 No	1 Yes 2 No
f Vi	D 00	To Be	axaminer?	Hospital: 1 ☐ Inpatient	2□ ER/Outpe	otient 3 DOA Oth	26. Plece of Death her: 42 Nursing Hon	ne 5 Residence	e 6 🗆 Other	(Specify)
Division of	After fune	Certification:	27. Manner of Deeth  1 Naturel  2 Accident  3 Suicide  5 Pending investigation  6 Could not be	28e. Data of Injury (Month, Dey Ye	28b. Tim Inju	ry Wor	ry et rk? I Yes 2 □ No	28d. Dascribe how	injury occurred	
Divi	To the Hospital or Attending within 24 hours effer deeth.  To the Funeral Director: After completely filled in by the fune		4 Homicide determined	building, etc. (S	pecify)	, street, factory, offica		City or Town, S	tete)	or Rural Route Number,
	n 24 hc	edical		sicien: To the best of my ner: On the besis of exe end manner stated.	y knowledge, d mination end/o	eath occurred at the tir r Investigation, in my o	me, dete end pleca, e opinion, deeth occurre	and due to the ceus ad et the time, date	e(s) end menn and pleca, en	er es steted. d due to the ceuse(s)
	within 2 To the	M	29b. Signature and till®gt certifier	mi		29c. Licens	2/6/2	29d.	Dete signed (	Month, Dey, Year) - 29 1998
	5		30. Name and address of person who co	DELAGAI	(Item 23e) (Ty	pe, Print) Joh	Ns Hopkin	is Geriat	TIC (0	Ner Bilt, M
ľ	Sta Registr		31. Date filed (Month, Day, Yeer)	32. Registral's	Signature	B. Spo	uls			1

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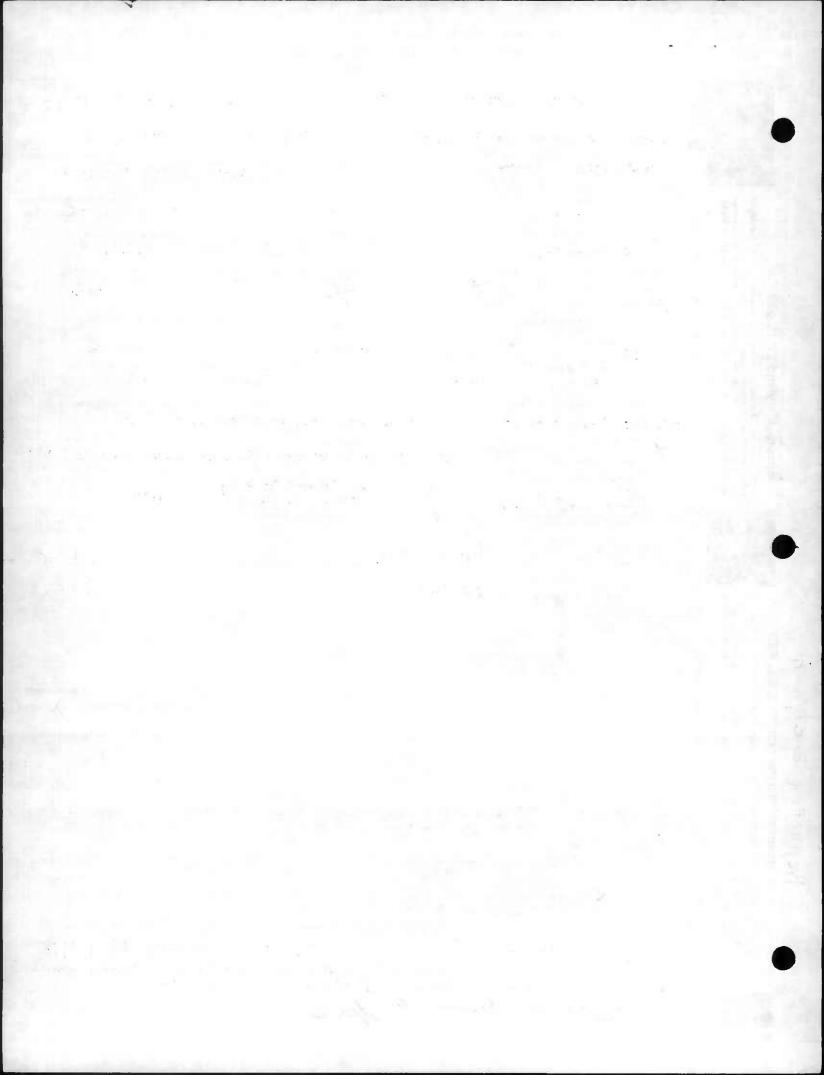
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Date of Deeth August 21 **ANDREWS** BENNETT **Physician** EVELYN 5:02 AM /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Carroll County General Hospital If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min. 218-07-1694 Yrs. April 12 1905 Maryland **Director** Usual Rasidanca of Dacadant the Marylend 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits r 28a-f show Ves 2 No MD Carroll Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23s or traumatic event, the Madical Examiner (wast be a U.S.A. 21157 69 W. Green St. Pages 1 and 2 should be filed within 72 hours after death 1 nent of Haalth and Mantel Hygiene.
sint: If item 27 Is marked other than "natural", or items 23, ury or other traumatic event, it a Menical Event or my Funerai 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 2 1 No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No white Specify: PV 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usuat Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Etamantary/Secondary (0-12) College (1-4or 5+) own home homemaker 11 18. Mothar's Neme (First, Middla, Maidan Sumama) 17. Fethar's Nama (First, Middla, Last) Be Tall Andrews Fannie Herman 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 69 W. Green St., Westminster, MD 21157 Mr. Jack Bennett - son 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pages Depertment of Important: If its any Injury or or Burial 2 Cramation 3 Ramovet from State Old Trinity Churchyard 8/24/1998 ChurchCreek MD 21622 Donation 5 Other (Specify) 22. Nama and Addrass of Facility
Thomas Funeral Home PA 21. Signature of Fupêral Service Licensee 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervet Batwean Onsat and Death **Physician** Immadiata Causa (Final disaasa or condition rasulting in daath) Hypotension /Medical Examiner Examiner BRady Cardia attending physician end for use es the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaquanca of): Physician/Medical Dua to (or as a consequanca of) 23b. Did tobacco usa contributa to the cause of death? Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? Completed complation of causa of daath? s certificate has b 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medicat axaminar? Bennett Be 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Funeral Dire
 Funeral Dire
 Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. Licansa numbar 29b. Signature end title of certifier M.D Jison Hym , M.P. D0052479 august, 21, 1998

30. Nama and address of person who complated cause of death (Itam 23a) (Type, Print) LISA Kim, M.D. at Carroll County General at 200 Memorial Westminster, mp 21150 Avenue Hospital 32. Pégistrar's Signatura 31. Data fited (Month, Day, Year) AUG 2 4 1998 Registrar

**DHMH 16 Ray 6/95** 

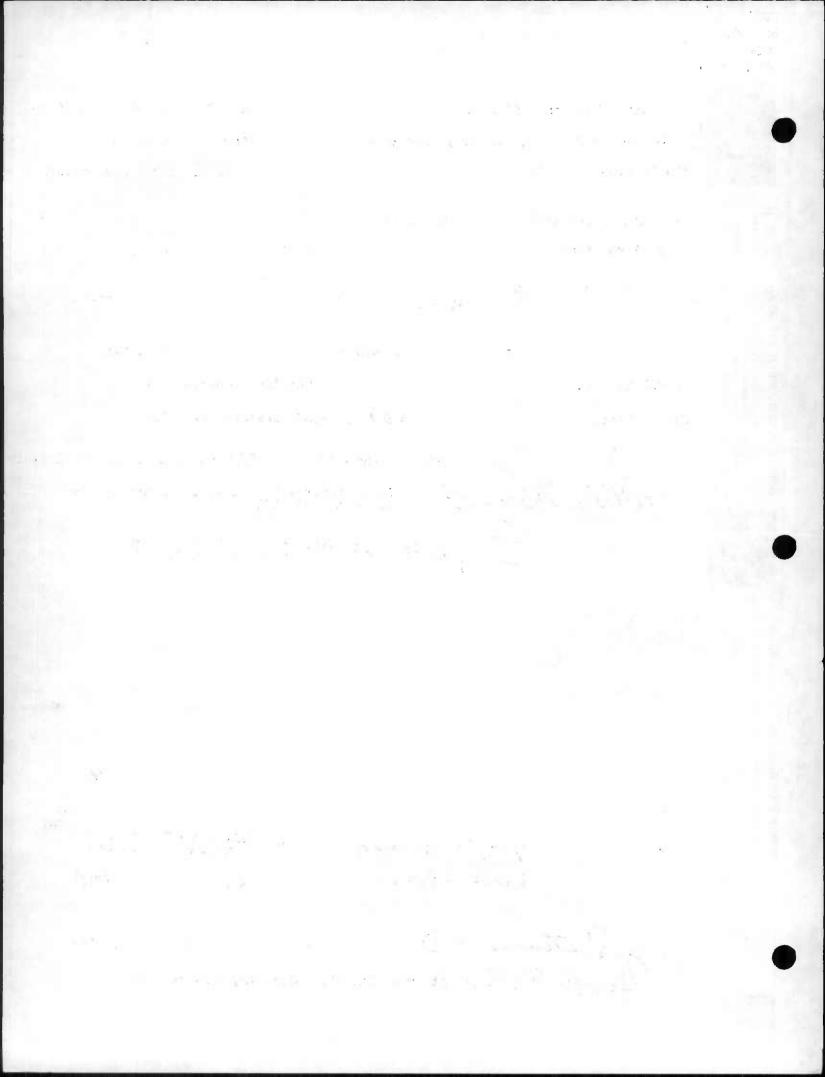


WRC ' 98-5095-017 ROBERT S.

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State of Maryland / Department of Health and Mental Hygiene

BLAS	SSIC				Certificat	e of	Death		Re	g. No.	40	007	O		
		1. Decedent's Name (First, Middle,	Last)						2. Date of Death Month		Year	3. Time	of Death		
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8	Examiner	A. Proditte his one office at the others.					4b. City, To	wn, or Loc	cation of Death	4c. County					
		POTOMAC RIVER	QUANTIC	O MARINE	BASE		INDI	AN H	EAD	Char	les				
	Funeral Director	5. Social Security Number 199 12 6789	6. Sex 7. A	ge (In yrs. last birth 72 Y	Months		If Under Hours	Min	8. Data of Birth (Month, Day, Jan. 22,	<sup>Уваг)</sup> 1926	9. Birthp Cour Peni	place (State ntry) nsylva	or Foreign ania		
P		Usuel Residence of Decedent									1				
arylar	de de la	10a. Stata 10b. County		10c. City, Town							1	0d. Inside (	Sity Limits s 25 No		
M ed	or 28a-f e be notified	Virginia Fauqui	er	Beale									, 2,2,140		
72 hours after death with the Maryland	al', or items 23a or 28a-f show Examinat must be notified at by Funeral Director	10e. Street and Number 7355 Botha Road			10f. Zip	Code	2271	2	10	g. Citizen of U.S.		ntry?			
r daa	r tems 23s where must	11. Marital Status	12. Was Dacedant Armed Forces	Evar in U,S.	13. Was Dece If Yes, spe	dent of h	lispanic Ori	gin? (Spe n, Puerto F	cify Yas or No- Rican, etc.)		ca - Americ ck, Whita,				
ours afta	Example Dv Fu	3 ☐ Widowed 4 ☐ Divorced	lf Yas, Giva Yaar or Dates:	10/7 77	1 ☐ Yes	2 🔀 No	Specify:			Specif	y: w]	hite			
d within 72 hours af	natural', soical Exe leted by	15. Decedent's (Specify only highest	Education grade completed)	16a. [	Decedent's Usu	al Occup	oation during mos	t of workir	100	6b. Kind of B	usiness/In	dustry			
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nd 2 should be file	h and	19e. Informant's Name/Reletionsh Kay B. Blassic	ip (Type, Print)						<i>i Route Number,</i> eton VA			Code)			
mit. Pagas 1 and	~ = 0	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (Sp.			Disposition (Na , crematory or o	ther pla	,	8		Oc. Location			irgir		
oermit. F	Department of Important: If any injury or pince.	21. Signature of Funeral Service L		1	22. Nama ai	nd Addre	ss of Facilit	ty							
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	cats has been s r, page 2 should Completed								1 Ye	s 2 No		death? Yes 2[	□ No		
delan: T	settifica rector, i	25. Was casa refarred to medical					26. Place	e of Death	(Check only one	9)					
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Attending Phys	ath. r: Atter th he funeral		ition 8/29/	98 Uni	me of jury	28c. Inju Wo 1 [	ry et rk? Yes 25	. (	28d. Describe ho	nt o	FOR P	lang	ENE		
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0.00	Sec (\$7)(0.25)	J. Per	lann,	W.D.		0.0	C.M.E.		A	UGUST	30,	1998			
		30. Nama and oddrass of person w	to completed causa of PCS tan	death (Item 23a) (1		eet,	Balt	imor	e, Maryl	and 21	L <b>20</b> 1				
	State	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	4 1										



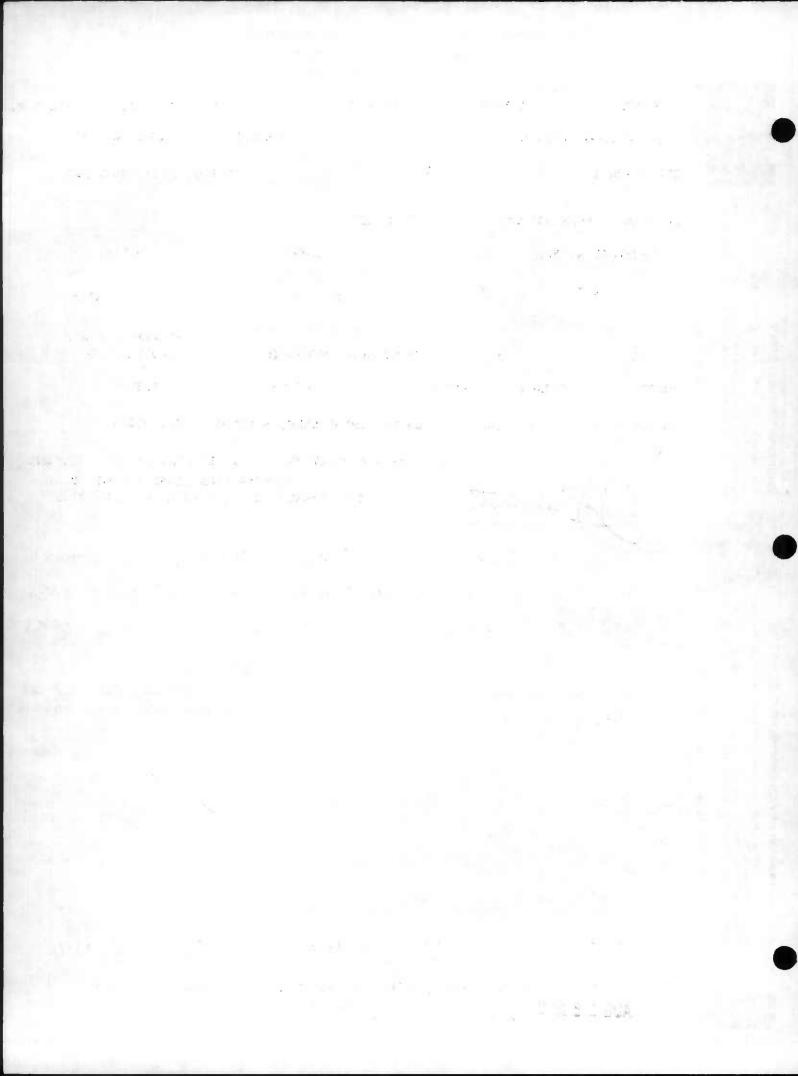
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** JOSEPH CARROW BRYAN, III 5:30 A.M AUGUST 15, 1998 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner GLEN BURNIE ANNE ARUNDEL 24 ARCHWOOD AVENUE If Under 1 Year If Under 24 Hrs. 9. Birthplece (Stete or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Deys Hours Min. 81 Yrs. JULY 9, 1917 212-12-9894 MARYLAND Director Usuel Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar name to notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21061 U.S.A. 24 ARCHWOOD AVENUE Funeral death 14. Race - American Indien. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc. it. Pages 1 end 2 should be filed within 72 hours after Detartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite my injury or other traumatic event, the Medical Examples 1 Never Married XX Married Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) HEATING AND AIR Elementary/Secondery (0-12) College (1-4or 5+) SHEET METAL MECHANIC CONDITIONING 12 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be LYDIA ASHLEY **JOSEPH** CARROW BRYAN, JR. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 68 ROCKYWOOD LANE, BALTIMORE, MD. 21211 JOSEPH C. BRYAN, IV (SON) 20b. Place of Disposition (Neme of cemetery, crematory or other piece) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 8/18/98 CENTREVILLE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) CHESTERFIELD CEMETERY 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 rest implications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, ist only one ceuse on each line. Approximate Intervel Between Onset end Deeth **Physician** CONGESTIVE HEART FAILURE /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner CARDIOVASCULAR DISEASE MARTERIOSCLEROTIC death certificate be executed physician and the burial-transit Due to (or es e consequenca of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury MELLITUS P.O. Box 68760 DIABETES Physician/Medicai that initieted events resulting in deeth) Lest 98 USB Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ULTILNEARCT DEMENTIA Division of Vital Records, À 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? s certificate hes b director, page 2 s 1 Yes 2 No 1 □ Ves 2 □ No Attending Physician: director, Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funerai 28e. Date of Injury (Month, Day Year) 27. Manney of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending or Attending efter death. Director: Aft 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 6 4 ☐ Homicide 24 hours efter Funeral Dire letely filled in b 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier INTERNAL Ilsha Lite D51104 MEDILINE 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

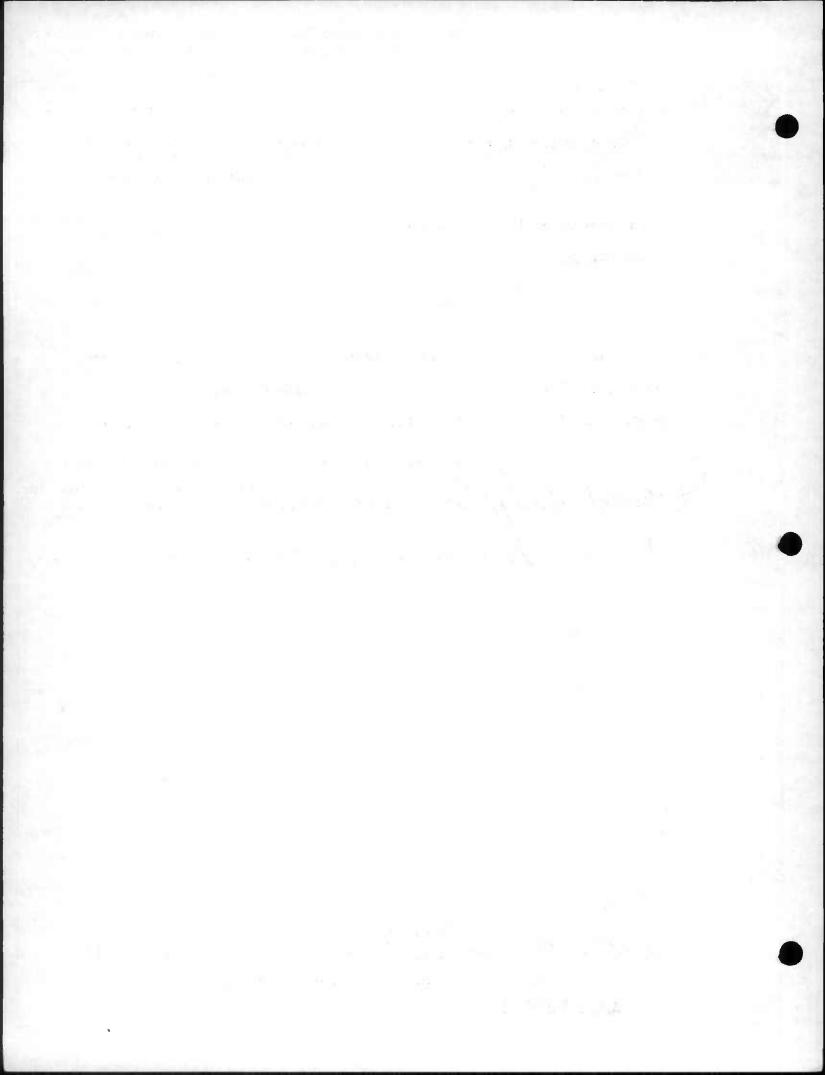
State Registrar USHA VEMULAKONDA, M.D., 4710 PENNINGTON AVE., BALTIMORE, MD 21226

INDIA DAY, Year 1998 325 Tegistres Signature S. Aparls



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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene ()

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** Mildred Christine Coomes 10:30pm August 1998 16, /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 1130 Old County Road Anne Arundel Severna Park If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2ĀF Months Deys Hours Min. 414-48-4146 65 Yrs. Sept 21, 1932 Massachusetts Director Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d Inside City Limits 7 is marked other than "natural", or frame 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Anne Arundel 1 ☐ Yes 2 X No Severna Park Director 10f. Zip Code 10e. Street and Number 10a, Citizen of What Country? 1130 Old County Road 21146 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Americen Indian, 11 Maritel Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Wldowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Hospice Home Health Aide 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be 1 nant of Haalth end Mental I int: If Item 27 is marked of Raymond J. Emely F. Hitchcock 0 Foley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1130 Old County Road, Severna Park, MD James H. Coomes, Sr. / husband other i 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete Aug 20 permit. Pages Depertment of Important: If it any Injury or o 1 XBuriel 2 Cremation 3 Removel from Stete Lakemont Memorial Gardens 1998 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) Funera Serv 22. Name end Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146
Shock, or heart feilure. List only one cause on each line.

495 Gov. Ritchie Hwy., Severna Park, MD 21146
Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner law requires that the death cartificate be axecuted physicien and the burial-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): as attending p for use as Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? ed by the a 1 Yes 2 No 3 Probably 4 Unknown can cel p 500 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? s peed s 24e. Wes en eutopsy Completed is certificate has director, page 2 1 Yes 2 No 1 Yes 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Magner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. fnjury et Work? Certification: After Naturel Accident Attending 5 Pending 1 Yes 2 No death. investigation ector: A 6 ☐ Could not be 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or At 4 ☐ Homicide 24 hours after Funeral Dire-lataly filled in b Certifying Phyelofan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature end title of dentifier 30. Name end eddress of person who completed ceuse of de th (Item 23e) (Type, Print) 900 Bestgate Rd. #300 Annapolis, MD 21401 31. Date filed (Month, Day, Year) AUG 1 8 1998

State Registrar SEE MANAGE TO THE PARTY

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** Month Alma Catherine Clark August 1998 2:30 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 507 Main Street Stevensville Queen Anne's 5. Social Sacurity Number If Undar 1 Yaar | if Undar 24 Hrs. Birthplaca (Stata or Foraign Country)
 MD 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1 M 2 N F 76 Yrs. 219-14-4246 Director 6, Usual Rasidance of Decedant with the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 ie markad other than "natural", or itema 23a or 28a-f show traumatic event, tra Mexical Examiner must be notified at 1 X Yas 2 □ No Director MD Queen Anne's Stevensville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 507 Main Street 21666 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Peges 1 and 2 should be tiled within 72 hours effer to Department of Health and Mentel Hygiene. Important: If fem 27 is marked other than "natural", or flee eny injury or other traumatic event. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Nevar Married 21X Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Homemaker Self. Unknown 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Harry Schepers Veronica Dockins 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 507 Main Street, Stevensville, MD C. Melvin Clark/Husband 21666 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1998 August 25, 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Stevensville Cemetery Stevensville, MD 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 106 Shamrock Road, Chester, MD Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner attending physician end for use es the bunel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated events rasulting in death) Last Due to (or as a consaquance of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? notel 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Wara autopsy findings available prior to complation of causa of death? been si Be Completed 24a. Was an autopsy performed? page 2 s 1 Yas 1 ☐ Yas 2 ☐ No this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funerat Director: After this certifica completely filled in by the funeral director, it 25. Was casa rafarred to medical 26. Place of Death (Check only ona) 1 Yas 2⊠ No Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2□ Accidant 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 3 Sulcida 6 Could not be datamined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a, Certifian Medical 29b. Signatura and titla of certifie 29c. Licensa numbar 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause of daath (Itam 23a) (Type, Print) Medical portra Suita 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State

I ... 19033

**DHMH 16 Rev 6/95** 

Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_						Certifica	ate of	Death		Reg. No	90	46853
П	Physic	ian	<ol> <li>Dacedant's Name (First, Middle, Martha H. Califf</li> </ol>	Last)					2. Data of I Month	Daath Da	y Year	3. Time of Death
V.	/Medi	cal							Aug.	- 8		
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-	Funeral		Anne Arundel Med 5. Social Sacurity Number		(In yrs. last birth	Month	dar 1 Yaar	Annapoli If Undar 24 H Hours Mi	rs. 8. Data of E		nne Aru	ndel hplaca (Stata or Foreign untry)
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	land ow		10a. Stata 10b. County		10c. City, Town	r Location						10d. inside City Limits
	Man a-f sh	to	Virginia None		Alexand	ria						1 TyYas 2 □ No
	or 28	Director	10e. Street and Numbar			10f. 2	Zip Coda			10g. Cit	izan of What Co	untry?
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00	hour tural	D D	3 Widowed 4 Divorced	Year or Datas:	40a D		Λ			1 101 15	Specify: Car	
Maryland 21215-0020	filed within 72 Hygiene. rther than "nai	Completed	15. Dacadent's (Spacify only highest Elementery/Secondary (0-12)	grada complatad)  College (1-4or 5+	·) (C	ecedant's Us Giva kind of v fa. DO NOT emaker	vork dona usa ratire	during most of w d)	vorking		ind of Businass/I	Industry
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/Jar		ToB	William Lee Hewi	tt				Barbara	Moore			
al	and and s m		19a. informant's Neme/Ralationship	(Typa, Print)	19b. N	lailing Addra	ss (Straet	end Number or i	Rural Route Num	ber, City o	or Town, Stata, Z	Zip Code)
≥ (i)	12 mg		Toxey H. Califf	(Husband)		Richa			exandria			
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Ba	permit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service Lic	Dans	1			of Glouc	ohn M. S ester St	Taylo	r Funera nnapolis	al Home Inc s, MD. 2140
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<b>X</b>	ician: Th certificate rector, pa	Be	25. Was case rafarrad to medical examinar?	Hospital:			Out	-	eeth (Check only	one)		
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			Mullen	· Of No	om c	) D	06054			8	1141	198
			30. Nema and address of person who									
			William P. Jones, 31. Data filad (Month, Day, Year) AUG 17			1035	Sha	ady Side	, Md.			
			21 Date filed (Month Day Vend	32. Registrar	0:							

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State of Maryland Department of Health and Mental Hygiene

Certificate of Death

	Physician	1. Decedent's Nam	e (First, Middle, L	ast)		00/	inoat	01	Doutin	2. Dete of D	eath Day	Year	3. Time of Death	
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	or 28,	10e. Street end Nu				10f. Zip Code				10g. Citizen of Whet C			ntry?	
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Maryland	S DE E	19a. Informent's Na	ame/Reletionship	(Type, Print)		19b. Maiiir	ng Address	s (Stree	et end Number or F	lurel Route Num	ber, City or Town,	Ste te, Zij	Code)	
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Baltimore,	pemit. Pag Department Important: I any injury o once.	21. Signature of Fu	meral Service Lice	onsee					ess of Fecility Kalas Fu	neral H	OME			
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Registrar

TRUE PROGRAMMENT OF THE STREET

#### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Nema (First, Middle, Last) Month **Physician** AUGUST 17, STEPHEN DONITHAN 11:10 PM FRANKLIN 1998 /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 1910 MALTRAVERS ROAD GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign
Country) **Funera** 1 M 2□ F Months Deys Yrs. 62 232-52-7800 10/21/1935 VIRGINIA Director Usuel Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinal mant be not less as the Maryler 1 ☐ Yes 2X No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 1910 MALTRAVERS ROAD 21060 U.S.A. Funeral deeth 12. Was Decedant Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race · American Indian, Bleck, White, etc. 2 should be filled within 72 hours efter ond Mental Hygiene.
Is marked other than "natural", or its X Yes 2 No 1952-If Yes, Give Year or Dates 1956-60 1 Never Merried 2 Merried altimore, Maryland 21215-0020 1 Yes 2√ No Specify: Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PROGRAMMER COMPUTER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) LUTHER HAT.T. DONITHAN DORTS PAULETTE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 st Depertment of Health end Important: If item 27 is in any Injury or other traur SHEILA ANN DONITHAN (WIFE) 1910 MALTRAVERS ROAD, GLEN BURNIE, MD. 21060 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition 1 X Burial 2 Cramation 3 Ramoval from State 4 □ Donetion 5 □ Other (Specify) GLEN HAVEN MEMORIAL PARK | 8/21/98 GLEN BURNIE, MD. 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signature of Funeral Service License any 1. cide 0 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset end Deeth Physician Immediate Ceuse (Final disease or condition resulting in deeth) /Medical METASTATIC ADEMOCALCIMOMA SEVENAL TO THE LINER Examiner MONTHS UNKNOWN ( PANCHERS LIKELY) n mary Examiner physician end s the burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as e consequence of) certificate be exec Box 68760. Physician/Medical Dua to (or es a consequence of) resulting in deeth) Lest as I 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. the signed by 1 Yes 2 No 3 Probably 4 Unknown EMO STAGE KIDNEY DISCASE þ Division of Vital Records. 24b. Wera eutopsy findings eveilable prior to completion of causa of deeth? HIGH BLOOD PRESSURE 24a. Wes en eutopsy performed? Completed peen page 2 certificate hes Prior REMAL MANS PLANTATION 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To After this 28a. Date of Injury (Month, Dey Yeer) innerel 27. Manner of Death 1 DiNaturel 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? or Attending 5 Pending investigation efter death. 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide 24 hours Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) To the Vithin 2 29b. Signature end title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) serand M 029296 1998 Domla -m AUGUST 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) M CUM=1 BALTIMORE, MD (SEVIAR) 901 E. FORT AVE . 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature

Registrar

State

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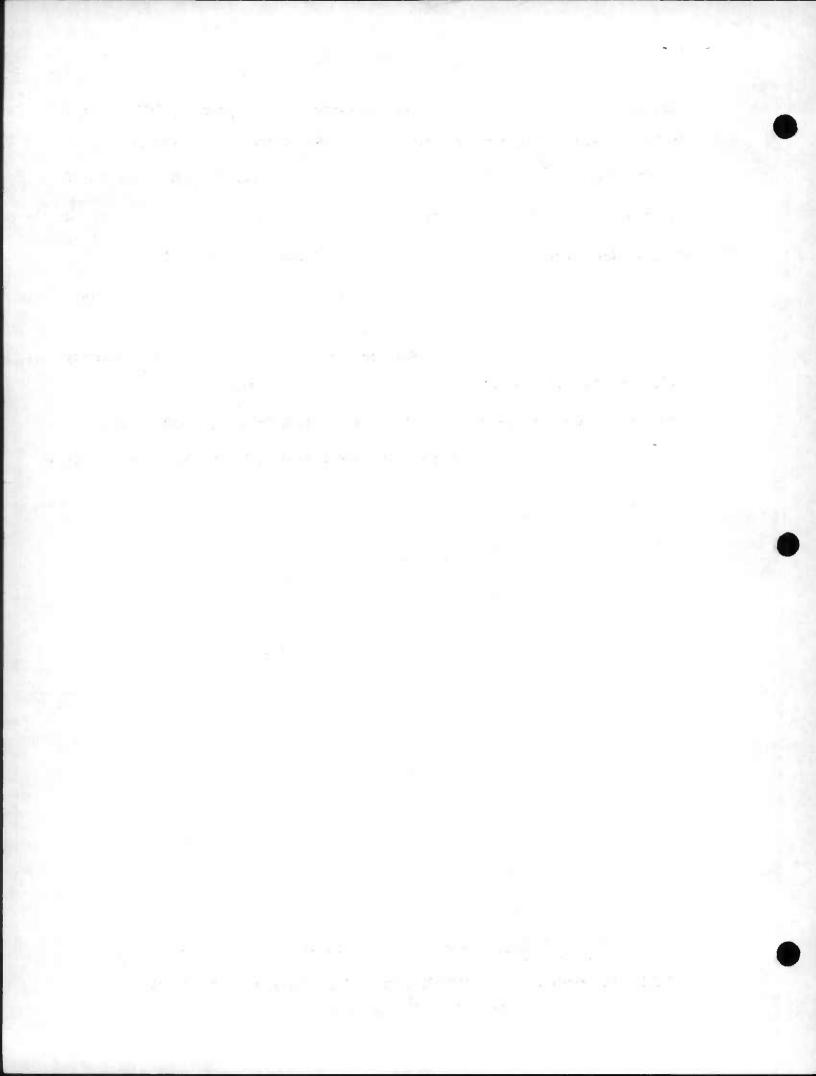
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uneral rector		215-09-8046	7. Age (In yn	s. last birthday) Yrs.	Months Days	Hours Min		th by, Year) 1917	9. Birthplace Country) Maryla	
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be notified at	Funeral Director	10e. Street end Number		Dareimo	10f. Zip Code			10g. Citizen of V	What Country?	
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al', or itar Examiner	by Fur	1 Never Married XX Married 3 Widowed 4 Divorcad	Armed Forces? 1 Yes 2/2/No If Yes, Give Year or Dates:	If	Yes, specify Cub	en, Mexican, Pue Specify:	rto Rican, etc.)		ck, White, etc.	
natur		15. Decedent's Edu	cation	16e. Deced	ent's Usuel Occup	pation		16b. Kind of Bu	usiness/Industr	У
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	To	Charles Henry Ha	cnemeister			Ruth V	Walsh			
aum a		19a. Informent's Name/Relationship (T)			-	and Number or F				
n 27 ner tr		Lillian E. Hachem				lace Balt	timore,	Maryland	21613	-21244
r ott		20e. Method of Disposition  XX Burial 2 □ Cremetion 3 □ F	20b.	Plece of Dispos cametery, cren	sition (Neme of netory or other pla	ca)	Date	20c. Location -	City or Town,	Stete
ury o		4 □ Donetion 5 □ Other (Specify)	La	akeview	Memoria.	L Park 8	8/24/98	Baltimo	re, Man	ryland
Important: If Item 27 is marke any Injury or other traumatic once.		21. Signature At Funeral Service Licens	00	22	Name end Addre	ess of Fecility Funeral	Home	DΛ		
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miner	lner	disease or condition resulting in death)	Due to Cance	or es e conseq	uenca of):	~	<u> </u>		Mo	^
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• Funeral Director: After this carifficate has been signed by the attending physicia pletaly filled in by the funeral director, page 2 should be datached for use as the bur	edical Certification: To Be Completed by Physician/Medical	Pert II. Other significent conditions condit	Due to Du	esulting in the understanding	aderlying cause given by the set of the stigation, in my cause given between the stigation.	26. Plece of Dener: 4 Nursing ry et rk? Yes 2 No	23b. Did 1	Yes 2 No en eutopsy ormed?  Yes 2 No one) dence 6 Oth how injury occurs  Street and Numb wn, State)  cause(s) end me date end plece, for	3 Probably  24b. Were evellebicompile of death 1 Yes  er (Specify)  red  per or Rural Rouender of Steel Stee	utopsy findir e prior to tion of cause ? s 2 No
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State of Maryland / Department of Health and Mental Hygiene () ASP Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Neme (First, Middla, Last) Month Dev Veer **Physician** BRIAN STEVEN HOWSER AUGUST 1998 1:55 A /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. Counfy of Death Examiner BALTIMORE UNIVERSITY HOSPITAL If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number If Under 1 Year 6 Sax 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min Yrs. 2-8-1975 23 MARYLAND Director 220-15-8453 the Maryland r 28a-f show 10a Stata 10h County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director ANNE ARUNDEL MD GLEN BURNIE 10g. Citizan of What Country? 10e. Street and Numbar 10f. Zip Code with "naturel", or itema 23a or e filed within 72 hours efter deeth wi si Hygiene. other than "naturel", or itema 23a vent, the Mootcal Examinet final to 505 KENT CIRCLE 21060 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Detes: 14. Race - Amarican Indian. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 XNo Specify by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elamentery/Secondary (0-12) College (1-4or 5+) 12 WRESTLER WRESTLING 7 Is marked other traumatic event, I 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Fether's Neme (First, Middla, Last) Be Peges 1 and 2 should be f nent of Health end Mentel I int: If item 27 Is marked of GEORGE WALTER HOWSER SHARON ANN COMPTON 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Relationship (Typa, Print) 505 KENT CIRCLE, GLEN BURNIE MD 21060 SHARON ANN HOWSER (MOTHER) item 2. 20b. Pleca of Disposition (Nama of cemetery, cramatory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition Date permit. Peges
Department of
Important: If it
any injury or o 1 Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 8-22-98 GLEN BURNIE, MARYLAND of Funeral Saprice Licensee 22. Name end Address of Facility SINGLETON FUNERAL HOME P.A. 1 SECOND AVENUE, GLEN BURNIE, MD 21061 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or es e consequença of) Examiner physicien end s the buriel-transit lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resuiting in daeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medicai Due to (or es e consequence of): 88 esn signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 3 Probably 4 WUnknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings available prior to completion of cause of death? should 24e. Wes en autopsy Completed certificate hes blirector, page 2 s The 1 XYes 2 No 15 Yes 2 No or Attending Physician: director. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) XXYes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Qay Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: After Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the heat of 1 Neturel 5 Pending shot police Subi ect by 1 Yes 2 No investigation 2 Accident Director: / 6 Could not be determined 281. Location (Straet and Number or Aural Route Number, City or Town, Stata) Gen Burnie Md. 3 Suicide 28e. efter 4 M Homicide Home 1512 Ingalls Road Glen Burnie, Md.

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es steted. 24 hours eft Funeral Di Hospital 29a. Certifier (Check only one) 25 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the tima, date end placa, end due to the cause(s) and menner steted. within 2 To the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar ose

aner 32. Fegistrar's Signature

O.C.M.E

AUGUST

111 Penn Street, Baltimore, Maryland 21201

18,1998

estanu, M.D

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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State Registrar 0 1998

29b. Signature and title of certified

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Joseph Pestaner, M.D. 32. Registrar's Signature

addrass of person who complated cause of death (Itam 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. Licansa number

O.C.M.E.

29d. Dete signed (Month, Day, Year)

AUGUST 18, 1998

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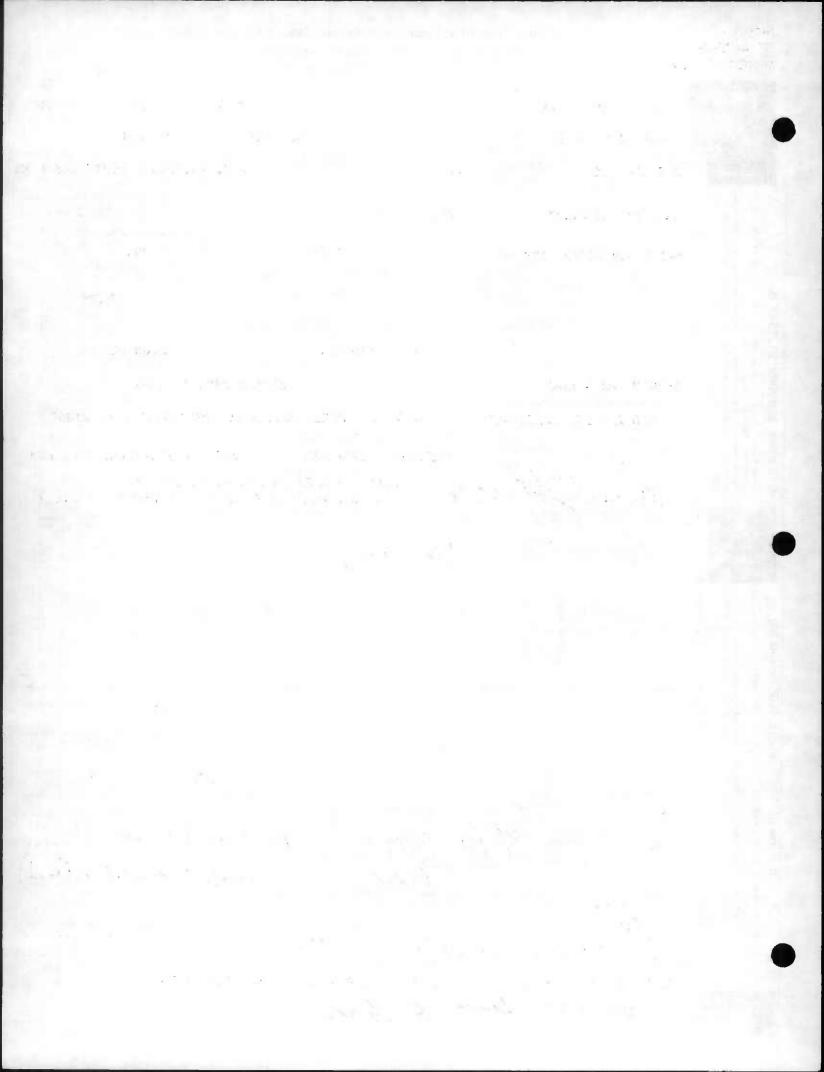
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by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ N If Yes, Give Year or Detes:	10	1 □ Ye	s 2 No	Specify:		Specify	v: WHI	TE
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	19e. Informent's Neme/Reletionship (7 ARNOLD RAY KINLAW						ROAD, PI			
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	Down &	2011	//	ZELL	ER FU	NERAL HON	ME, P. O. TY ROAD,		_	nD 21802
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J. Laron Locke M.D.

31. Dete filed (Month, Day, Year)

AUG 2 4 1998



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death James Philip Keane Month 12:10 PM **Physician** JAMES KEANE AUGUST /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGIES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 10 M 20 F Hours Director 018-22-2502 Jan.14,1929 Massachusetts Usual Residence of Decede the Maryland worle 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director VA Arlington Arlington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3012 South Grant death Street Funeral 22202 S A 14. Race - American Indian, 12. Was Decedent Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status Black, Whita, atc. 2□No1952 hours after 1√2 Yas 2 ☐ If Yas, Giva Year or Dates: 1 Never Married 2 Married 21215-0020 1□ Yas 2♥ No Specify: Specify: White À 1979 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within 72 Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Naval Officer  $5 \pm$ Federal Gov altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nam 27 is married oth any Injury or other traumatic event pages. Be John Matthew Keane Marie Catherine Calkins 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patricia M. Keane Roche (sister) 6 Reardon St. Quincy, MA 02169 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stala 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 8/22/98 Brentwood, Md. 22. Nama and Addrass of Facility John M. Taylor Funeral Home Inc 21. Signature of Funaral/Service Licens 147 Duke of Gloucester St. Annapolis, Md.21401 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical WITH COMPLICATIONS MULTIPLE INJURIES Examiner Examiner certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Dua to (or as a consequence of): physician s the buriel 68760 Physician/Medical Dua to (or as a consequence of): Box ( P.O. P Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by ti d be detach. 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 8 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28d. Describe how injury occurred
PASSENGER OF AUTO INVOLVED IN 27. Manner of Death Medical Certification: 26a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yas 2 No 2 Accident 3 Suicide 08-08-98 A COLLISION WITH MINIVAN 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) SOLOMONS DSLAND RD Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide HARWOOD MARYLAND STREET 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number

State Registrar MARIO

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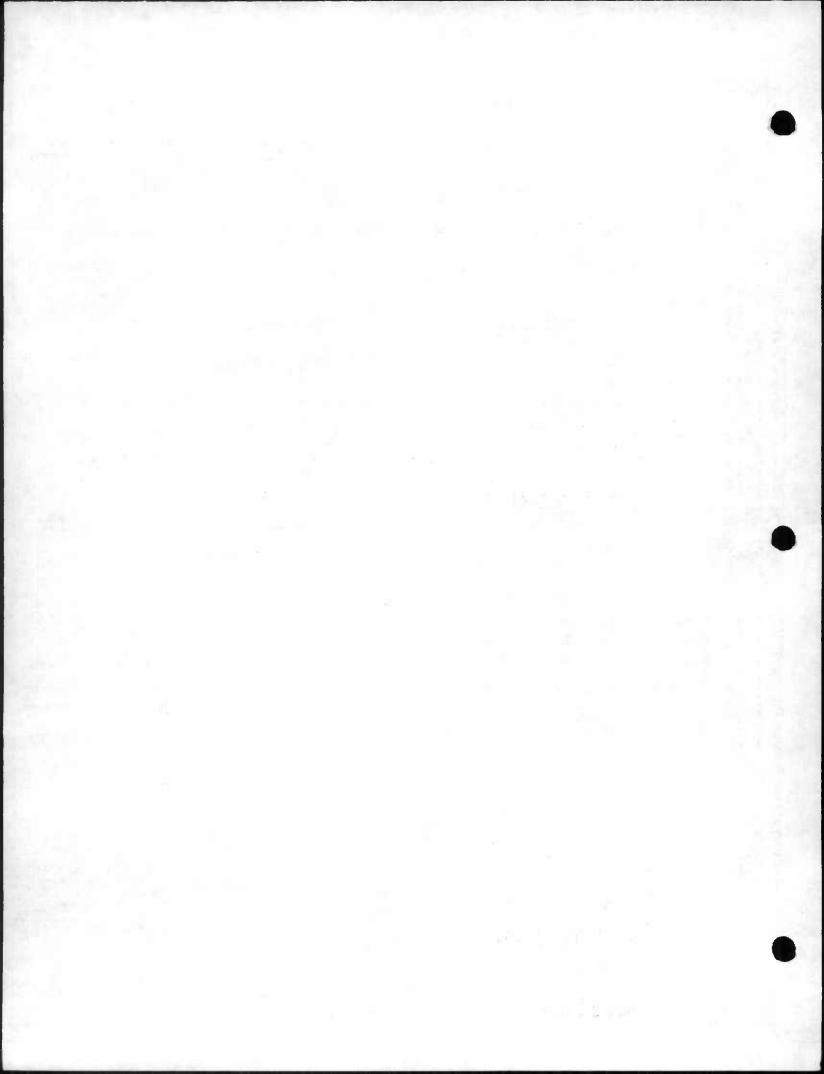
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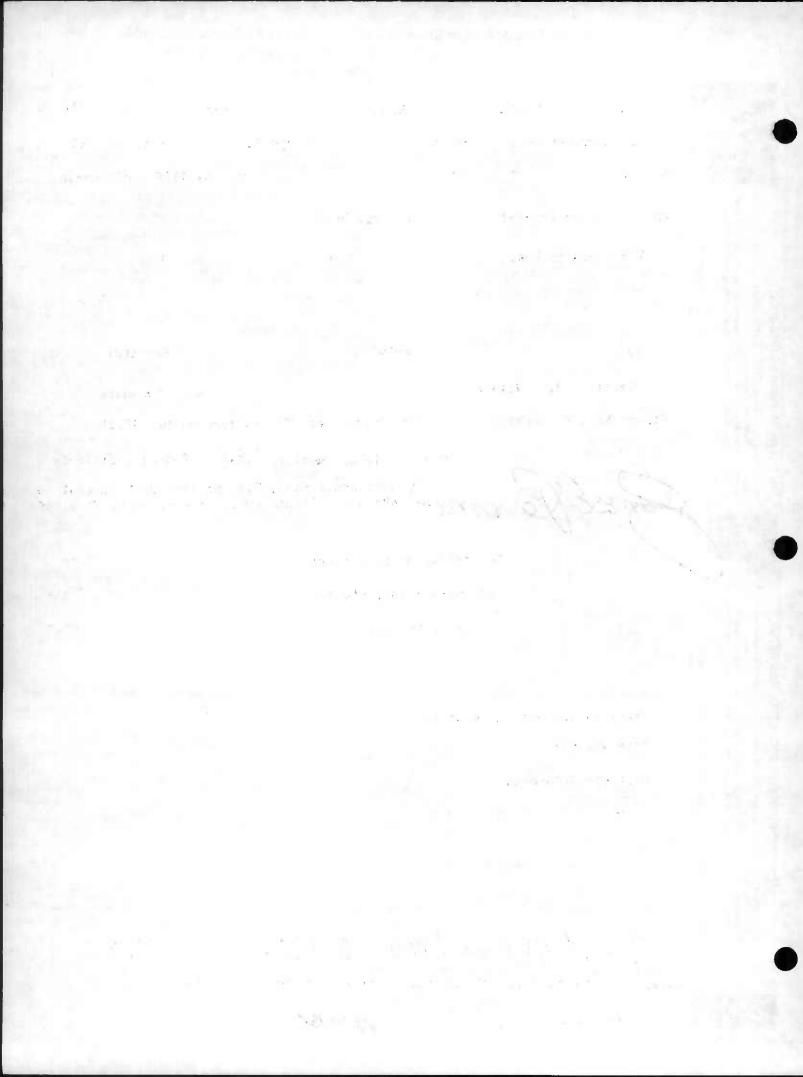
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HOSPITAL DRIVE, CHEVERLY, MARYLAND 2078S

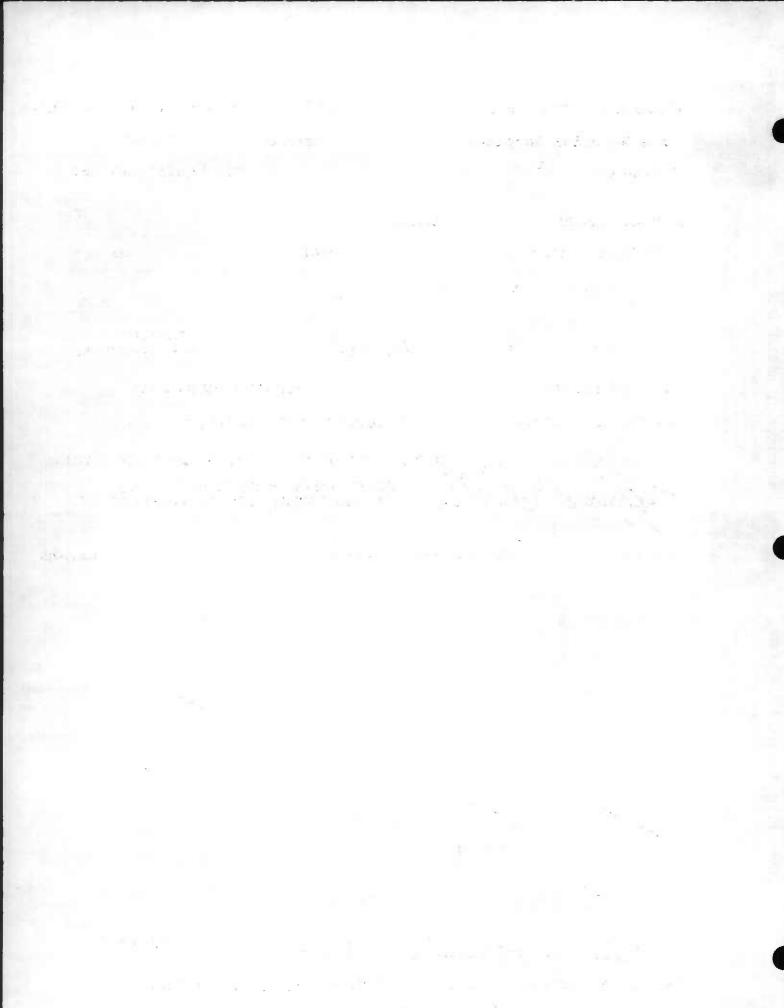


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yes **Physician** GEORGE ALEXANDER LEHMANN 14 1998 4:30PM August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner The Memorial Hospital Easton Talbot 7. Age (In yrs. last birthday) If Under 1 fear If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB. 12, 1932 5. Social Security Number 6. Sex 12 M 2□ F 9 Birthplace (State or Foreign **Funeral** MARYLAND 215-28-0410 Director 66 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 N Yes 2 No Directo MARYLAND TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23s or Medical Examiner must be r 116 HUGHLETT STREET 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X Yes 2 □ No 1951 – 8 Yes, Gave Year or Dates: 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2N Married Lehmann 21215-0020 1 Ves 2 XNo Specify: by 3□Widowed 4□Divorced WHITE Completed 15. Decedent's Education ify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify or PLUMBING/ than the College (1-4or 5+) Elementary/Secondary (0-12) CONTRACTOR HOME IMPROVEMENT 12 Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name /First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental MAX ERICH LEHMANN ELIZABETH HOLDA GAIDA 19b, Mailing Address (Street and Number or Flural Floute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hem 27 i ROBERTA LEHMANN/WIFE 116 HUGHLETT STREET, EASTON, MD 21601 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 8 Department of Important: If any injury or once. CAMBRIDGE CREMATORY 8/15/98 CAMBRIDGE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22 Name and Address of Facilit ZELLER FUNERAL HOME, P. O. BOX 207, cnare 106 MAIN STREET, EAST NEW MARKET, MD 21631 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death ny one cause o Physician Immediate Cause (Final disease or condition resulting in death) /Medical Mesotheliona months Examiner Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that enhance events resulted.) Due to (or as a consequence of): physician a s the burial-Division of Vital Records, P.O. Box 68760 certificate be Physician/Medical Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): 997 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown à à 24b. Were autopey findings available prior to 24a. Was an autopsy Completed completion of cause of death? MI certificate has b linector, page 2 s 1 Yes 28 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1-Inpatient 2 ER/Outpatient 3 DOA Certification: To 報 27. Manne of Death 28s. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 El Natural Attending 5 Pending 8/99 7 M 1L 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No investigation 2 Accident after death Director: // 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) A 24 hours Direction of Funeral Direction of Funeral Direction of Funeral Direction of Funeral Property of Propert Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 1 To the 9 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS DESHIELDS, M.D., 219 S. WASHINGTON STREET, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar AUG 2 4 1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 1998 Lawrence 7:54 PM August 14 Lovejov /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 6. Sex 1. 1 MM 2 □ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Yrs 74 Director 006-14-0722 July 24,1924 Maine Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Pagas 1 and 2 should be filed within 72 hours after death with the Marylas nent of Health and Mental Hyglone.
and: If item 27 is marked other than "naturel; or items 23s or 28s-f show ury or other traumatte event, this Medical Examples man be notified at 1 Yes 2 No Director Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 330 Londontown Road 21037 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ≦ Yes 2 □ No If Yes, Give Year or Detes:1942–46 Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Printer Federal Government 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Marshall Lovejoy Elizabeth Levesque 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Kathleen L. Cassidy/Pers. Rep. 330 Londontown Road Edgewater, Md. 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Paga Department of Important: If eny injury or once. Metropolitan Crematory 8/17/98 4 ☐ Donetion 5 ☐ Other (Specify) Alexandria, Va. 21. Signature of Funeral Segrice Licensee George P. Kalas Funeral Home, P.A. 2973 Solomons Island Rd. Edgewater, Md. 21037 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner 2010 physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. Physician/Medical Due to (or es e consequence of): signed by the at d be datached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were eutopsy tindings evaileble prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: Be 25. Was case reterred to medical examiner? 26. Piace of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 ONatural To the Hospital or Attending within 24 hours after death.

To the Funerel Director: Afte completely filled in by the fun-5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical (Chack only QCM2 29b. Signature and title of certifies 29c. License numbe 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 894 n this

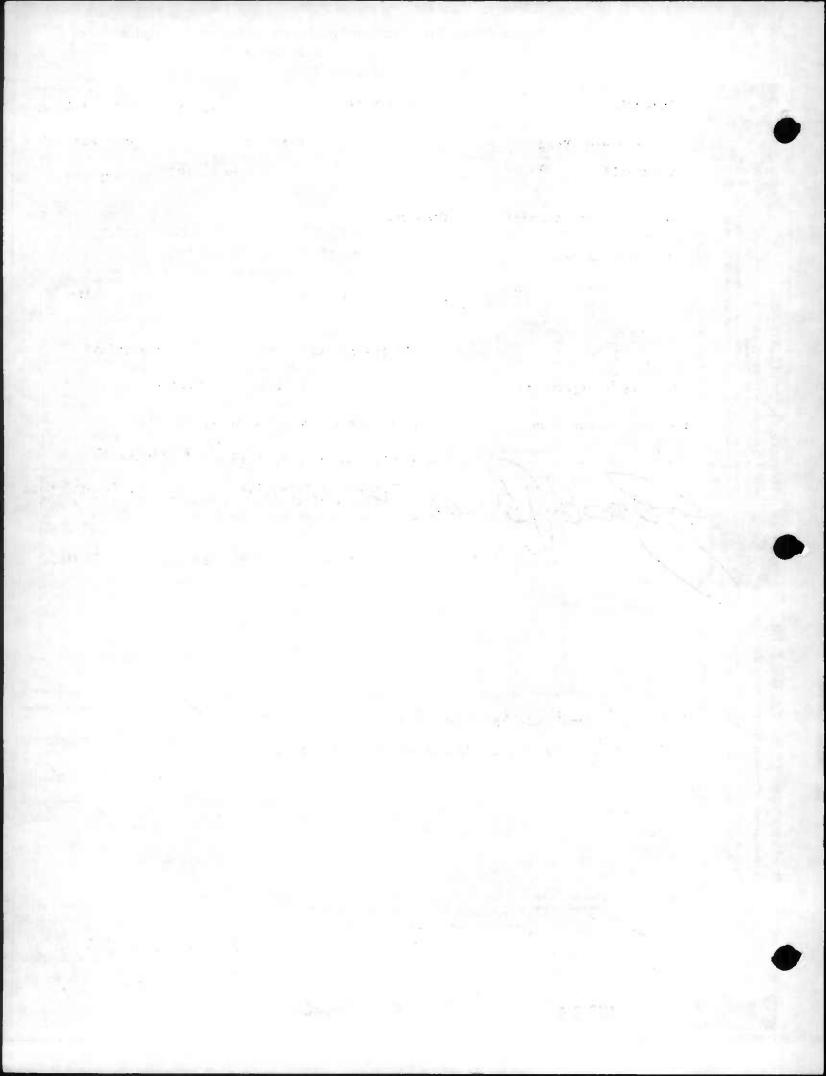
State Registrar

1.	Decedent's Name (F	rst, Middle, L	est)			mout	01	Death	2. Date of D	Reg. No.	200	3. Time of Death
n al	Charles		nver	McElha	anon				AUGUS	T 25, 19	Year 98	5:56 P.M
48	Fecility Neme (If not	institution, g	ve street and num	ber)				4b. City, Town, or	Location of Dea	th 4c. County	of Death	
	MALCOLM (					17.14	11/	CAMP SP				EORGE'S
4	Social Security Number 429-24-975 sual Residence of Dec	0	Sex 7 1⊠M 2□F	. Age (In yrs.	last birthday) Yrs.	if Under Months			8. Date of B (Month, I April	irth Day Year) 22,1922	9. Birthpla Country Arka	ce (State or Foreigr y) ansas
-		o. County		10c. Ci	ty, Town or Lo	cation					100	d. Inside City Limits
V:	irginia	Fauqui	er	Wa	rrento	n						1 ☐ Yes 2€No
Luneral Director	De. Street and Number						Code			10g. Citizen of	What Countr	y?
	7854 Welli	ngton	Drive				2018	36		U.S	S.A.	
11	Marital Status     Never Married     Widowed 4		12. Was Deced Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	es?		Was Dece f Yes, spe 1 ☐ Yes		Hispanic Origin? ( pan, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	lo- 14. Rac Bla Specil	ce - America ck, White, et y: whi	c.
	15.	Decedent's E	ducation ade completed)		16a. Dece	dent's Usu	el Occu	pation during most of we	orkina	16b. Kind of B	usiness/Indu	stry
	Elementary/Seconda		College (1-	4or 5+)			se retire	ed)	, nuig	U.S. A	ir Fo	rce
4.	S Sabada blassa (Sina	A B district of a s	3		Colon	ет		40. Mathada Na	ma /Cine Adidd			ICE
1	7. Father's Name <i>(Firs</i> unobtainab		U .					(	McElhano	le, <i>Maiden Sum</i> ar On	119)	
-	9a. Informent's Name		(Type, Print)		19b. Mallin	ng Address	s (Stree	t and Number or F			, State, Zip C	Code)
	oyce B. Lu				7854	Well	ing	ton Driv	e, Warre	enton VA	2018	6
20	a. Method of Disposit				Place of Dispo	sition (Name	me of	ice)	Date	20c. Location	- City or Tow	n, State
	1 ☑ Burial 2 ☐ Ci 4 ☐ Donation 5 ☐			tate				al Cem.	Sept 8	Arlingt	on , V	Virginia
2	1. Signature of Funera	Service Lige	Mc Jon	nell	//			ess of Facility M.	oser Fu	neral Ho		c.
d	nmediate Cause (Fina iseese or condition esulting in death)		d.	Due to (	or as a consec	uence of): US C	ELL	E PULMON				
u	equentially list conditi any, leading to imme- ause. Enter Underlyin ause (Disease or inju- lat initiated events esulting in deeth) Lest	diate g y	c. <u>DEEP</u>		S THROM or as a conseq			GHT LOWE	R EXTRE	METIES		
Pe	ert II. Other significan	t conditions	contributing to dea	ith but not res	sulting in the u	nderlying (	cause g	iven in Part i.	23b. Di	d tobacco use co	ontribute to t	the cause of death
_									10	¥Yes 2□ No	3 ☐ Probe	ıbly 4 ☐ Unknow
-									24e. We pe	as an autopsy formed?	avai	e eutopsy findings lable prior to pletion of cause eath?
Pe									10	Yes 2□No	1 🗆	Yes 2 No
	5. Was case referred to examiner?	o medical	Hospital:				Ot	the eart	eath (Check only			
27	1 ☐ Yes 2 ☒ No 7. Manner of Death	_	1 X In		ER/Outpatier		UA	4 LI Nursing	7	sidence 6 Dot		
	1 X Natural 5 2 ☐ Accident	Pending investigate	(Month	, Day Year)	Injury	М		Yes 2 No		(Street and Num		Doute March as
	4  Homicide	determine	building	g, etc. (Speci	iome, farm, sti fy)	eet, factor	у, опісе			own, State)	Der Or Hurar	House Wallinger,
Certific			hysician: To the b					ime, date and plac opinion, death occ				
2			miner: On the bas	sis of examina er stated.								
- 1	(Check only 2	Medical Exa		er stated.			c. Licen	se number		29d. Date sign	ed (Month, D	ay, Year)
29	(Check only 2 (Check only one) 2 (Check only one)	Medical Example of certifier	miner: On the bas and manne	Sylve	ra	29	СО	27148		AUGUS'	г 27,	
Σ 29	(Check only 2 one)	Medical Exa of certifier	o completed cause	of death (Ite	m 23a) (Type,	Print) 8	CO 39 M			AUGUST	r 27,	1998

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State of Maryland / Department of Health and Mental Hygiene 268

				Certificate of	Death	R	eg. No.	.0000
	1. Decedant's Nama (First, Mid	dia, Last)			W 1194	2. Data of Dea Month		3. Tima of Death
Physician /Medical	Valentine		Ma	ajerowicz		August	14, 1998	11:45 am
Examiner	4a Facility Nama (If not institut	ion, giva street and number	)		4b. City, Town, o	or Location of Daath	4c. County of De	ath
	716 Pasadena	Road		-1, 11	Pasad			ne Arundel
Funeral Director	5. Social Sacurity Number 217–26–0969	6. Sex 7. A 1 2 M 2 □ F	ge (In yrs. last birthe	Months Day				irthplaca (Stata or Foraig Country) aryland
2 .	Usual Rasidance of Dacedant		10c. City, Town o	- Lastina				
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or 28a-f si or notified Nirector		e Arundel	Tasau					
th with the Ma 23s or 28s-f s ust be notified all Director	716 Pasadena	Road		10f. Zip Coda 2112		1	0g. Citlzan of What 0	Country?
al, or items Examinar in by Furner	11. Marital Status  1 Nevar Married 2 A Marital 3 Widowad 4 Divorce		?	13. Was Decadant of If Yes, specify Cu 1 ☐ Yas 2 ☑ No		(Specify Yas or No- arto Rican, atc.)	14. Race - An Black, Wh Specify:	nerican Indien, uita, atc. White
and within 72 ho ygiene. Ner than "natural, the the Medical. It, the Medical.	(Specify only high	ent's Education east grada complated)	- (6	ecedent's Usual Occ Giva kind of work don ifa. DO NOT use reti	upation a duning most of w	vorking	16b. Kind of Businas	s/Industry
er than	Elementary/Secondary (0-12)		5+)	ectrical	Contract	or	Electr	ical
Mantal Hy Mantal Hy rhad oth ritic even To Be	17. Fathar's Nama (First, Middle William Maj	a, Last) erowicz			18. Mother's N	an Sk	Maidan Sumame) ladal	
M M M M M M M M M M M M M M M M M M M	19a. Informant's Name/Ralatio		19b. N	Mailing Addrass (Stra	at and Number or	Rural Routa Numbe	r, City or Town, State	, Zip Coda)
10 and 20	Bill Majerowicz			Pasadena				
f Has f Has flem 3	20a. Mathod of Disposition		20b. Place of D	Disposition (Name of crematory or other p		Date	20c. Location - City of	or Town, Stata
Page ent o nt: III i	1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other		8	ridge Memo		Aug 17	Elkridge,	MD
nit orta	21. Signature of Funyral Service			22. Nama and Add	rass of Facility	2330		
POT P	1000	(N/A 0	- 11	Barranco	& Sons,	P.A. Seve	rna Park	Funeral Hom , MD 21146
Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. ( )e tas	Dua to (or as a co		ll Casina	mofflel	- Uof	4 mos
ficate be elecu-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>d</b> c	Dua to (or as a co					
平 200 年	resulting in death) Last	L d						
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that the do ned by the detached y Physis	History of Sa	all Cell Cas	4	Λ	ne 1997	19	/	Probably 4 Unknown
sw requires as been sign 2 should be pleted b	and treated	wift chemo	blergog	and fad	iation	24a. Was a perfor		Ware eutopsy finding available prior to complation of cause of death?
The The Com						1 🗆 Y	as 20 No	1 ☐ Yas 20 No
# 65 W	25. Was case referred to medic examiner?	cal lac			26. Place of D	Death (Check only or	na)	
Physici this ca rat direc : To E	1 Yes 2DM5	Hospital: 1 ☐ Inpa	tiant 2 ER/Outp	atient 3 DOA	Other: 4 Nursing	Homa 5 Resid	ance 6 Othar (Si	pecify)
ding Ph Aller th funeral tion:	27. Manner of Death  1 CNatural 5 Pend 2 Accident invest	28a. Date of In (Month, D	jury ay Yaar) 28b. Tir Inji	ury W	jury at lork? □ Yas 2 □ No	28d. Dascribe h	ow injury occurred	
he Hospital or Attending P n 24 hours after death. he Funeral Director After a pistaly illed in by the tunes edical Certification:	3 ☐ Suicide 6 ☐ Coul	manner 28a. Place of I	njury - At homa, farn atc. (Specify)	n, street, factory, offic	е	28f. Location (S City or Tow	itreet and Number or n, State)	Rural Routa Number,
To the Hospital within 24 hours a To the Funeral C completely filled Medical Ce		ring Physician: To the bes at Examiner: On the basis and manner:	of axamination and/					
To the Hos within 24 h To the Fun completely	29b. Signature and title of certif	1	16 Les	29c. Lica	nse number	7	Au (1), A	onth, Day, Year)
	30. Name and address of purp	n who completed clause of	1th (Itam 23a) (T	ype, Print)	11	2.(//	8. 11	210()
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month CAROLYN HOWELL MUTCH 14, 1998 August /Medical 6:15am 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Hospice House Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F Yrs. **Director** 216-40-1117 86 Oct. 9, 1911 New York Usuei Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Funeral Director Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 21403 208 A Victor Parkway U.S.A. or itams 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2月 No If Yes, Give 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 → Merried 21215-0020 1 Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 traumetic event, Baltimore, Maryland permit. Pages 1 and 2 should be file Depertment of Health end Mental Hy Important: If Item 27 is marked other any liquy or other traumatic event once. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be G. Rushton Howell Carol Frye 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) D.A. Gordon Mutch (spouse) 208 A Victor Parkway Annapolis, Md. 21403 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Washington Mem. Cemetery 27/98 Valley Forge, PA 22. Name end Address of Fecility John M. Taylor Funeral Home ice Licensee 147 Duke of Gloucester St. Annapolijs, Md. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Physician /Medical Immediate Ceuse (Finel disease or condition resulting In deeth) Examiner Examiner The law requires that the death certificate be executed been signed by the attending physician end should be deteched for use as the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying course given in Pert I. 23b. Did tobacco use contribute to the cause of death? lar 1 Yes 2 No Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy certificate has 2 1 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury et Work? 5 Pending investigation To the hosping, within 24 hours effer death.

To the Funeral Diractor: After the funeral high the further than the further th 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. (Check only 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, 30. Neme end eddress of person 1340 we who completed cause of deeth (Item 23a) (Type, Print) perovi 31. Dete filed (Month, Dey, Year) AUG 1 9 1998 32. Pegistrer's Signature State Registrar

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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle artha rrison City, Town, or Location of Death if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1 □ M 2 😾 Yrs. Dec. 10, 343-18-4275 Illinois Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 981 Lanna Way 21401 U.S.A. 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2 No Specify 3√2 Widowed 4 □ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Rebecca Fitzgerald William Seipp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 1709 P St. NW Washington D.C. 20036 William M. Morrison Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 8/18/98 Brentwood, Md. 22. Name and Address of Facility John M. Taylor Funeral Home Inc. 21. Signature of Funeral Service L 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart faiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or conditio resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of ceuse of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examine

**Physician** 

/Medical

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Pegas 1 and 2 should be filed within 72 hours after death with 1 nent of Health end Mental Hygiene.
Int: If item 27 is marked other than "natural", or itema 23a or itary or other traumatic event, its Medical Examination

of Health e

permit. Pega Department Important: If any Injury or

Baltimore, Maryland 21215-0020

physicien end the buriel-transit 80 for use es signed by the a s certificata has t director, page 2 s director.

The law requires that the death certificate be asscuted

Division of Vital Records, P.O. Box 68760,

Examiner Certification: To

Physician/Medicai þ Completed Be

or Attending Physician; this funeral After death. after deat Director: 24 hours Hospital To the Hosp within 24 ho To the Fune completely f

Registrar

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(Check only one)

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medical examiner?

1 ▼ Yes 2 □ No 26. Ptece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Menger of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end maintened at the time, date and place, and due to the cause(s) and manner stated. 29c. License number **D28640** 

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, P/int) Jeffrey Briggs M.D.

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State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Month Physician 15 8:50 AM Pauline Norma Murray 1998 August /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foraign Country) **Funeral** 1□M 2XF Months Days Hours Min Yrs. 65 Director Dec. 19,1932 578-42-8126 Wash., D.C. Usuel Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yas 2 No Director Md. Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1520 Crownsville Road 21032 USA death Funeral 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give<sup>3</sup> Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Stetus permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "naturel", or iten any injury or other treumatic event, in Medical Exercises once. Black, White, etc. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2√□ No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Govt. 12 Secretary 18. Mother's Nama (First, Middle, Maiden Sumema) 17. Father's Neme (First, Middle, Last) Be Frank Nichter Norma Gibb 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Faith M. Lowery / sister 3705 Everton St. Silver Spring, Md. 20906 20c. Location - City or Town, State 20906-4381 20b. Place of Disposition (Neme of cernatery, cremetory or other pleca) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 8-18-98 Suitland, Maryland 22. Name and Address of Fecility 21. Signature of Funeral Service Licansee John M. Taylor Funeral Home, Inc. ar 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one ceuse on aach line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel disaasa or condition resulting in death) 8/7/96 MANGEN Examiner Examiner LUNCET physician end the buriel-transit Sequentially list conditions, if eny, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury Due to (or as a consequence of): certificate be Physician/Medical thet initieted events resulting in death) Last Dua to (or as a consaquanca of): as 980 ŏ Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the Yes 2 No 3 Probably 4 Unknown signed by i p 24b. Were eutopsy findings eveilable prior to 24a. Was an autopsy Completed (190) completion of cause of death? hes 1 ☐ Yas 2 ☐ No hypertension 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ■ ER/Outpatient 3 ■ DOA this 28a. Date of Injury (Month, Dey Yeer) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation Natural 2 Accident 1 Yes 2 No deeth. efter deeth Director: 6 Could not be 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homicide 6 Hospital 24 hours Funeral 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) end manner steted. edical To the Hosp within 24 hor To the Fune completely fi 29c. Licensa numbar 29b. Signature and title of config 29d. Date signed (Month, Dev. Year) pleted cause of death (Item 23e) (Type, Pgint) address of person who Annapolis 21403 MAR Registrar

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State of Maryland / Department of Health and Mental Hygiene 🔾 🤉 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Day **Physician** Orian Stewart Parker, Jr. 20, Aug. 1998 6:50 am /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2273 Hudson Rd. Cambridge Dorchester Hours Min. 8. Deta of Birth (Month, Dey, Year) Mar. 30, 1928 Maryland 5. Social Security Number 6. Sex M 2□ F If Undar 1 Yaar 7. Aga (In yrs. lest birthday) Birthpiaca (Stete or Foreign Country) **Funeral** Deys Yrs. 579-40-1393 70 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or items 23a or 28a-f ehor the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Maryland Dorchester Directo Cambridge 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 2273 Hudson Rd. Funeral 21613 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Navar Married 2 N Married 1 ☐ Yes 2 XNo Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Meat Cutter Grocery treumstic event, rmit. Pagas 1 and 2 should be file partmant of Haalth and Mental Hy portant: If item 27 is marked oth y Injury or other treumatic event 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Orian Stewart Parker, Sr. Anna Frischknecht 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) Helen W. Parker/Wife 2273 Hudson Rd., Cambridge, MD 21613 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Paga Department of Important: If eny Injury or once. 4 ☐ Donetion 5 ☐ Othar (Specify) Cambridge Crematory 8-24 Cambridge, MD 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Curran-Bromwell Funeral Home, P.A. kast. Enter the disease, or complications that caused the deeth. Do not antar tha mode of dying, such es cerdiac or respiretory errest, shock, or near failure. It only one eause on each line. MD 21613 Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel diseasa or condition resulting In death) Examiner Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Dua to (or es e consequence of) attanding p bean signed by tha a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to 24a. Was an autopsy Completed completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitei: 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Homa 5 PResidence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28e. Dete of Injury (Month, Day Year) funaral 27. Mannet of Death 28c. injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) ۵ 4 Homicide To the Hospital or A within 24 hours aftar To the Funerel Dire complataly filled in b edical 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end dua to the causa(s) and manner stated. 29b. Signetura end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 98 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

509 Idlewilde Ave, Easton, MD 21601

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32. Registrar's Signeture

State Registrar David H. Smith, M.D.,

31. Date filed (Month, Day, Year)

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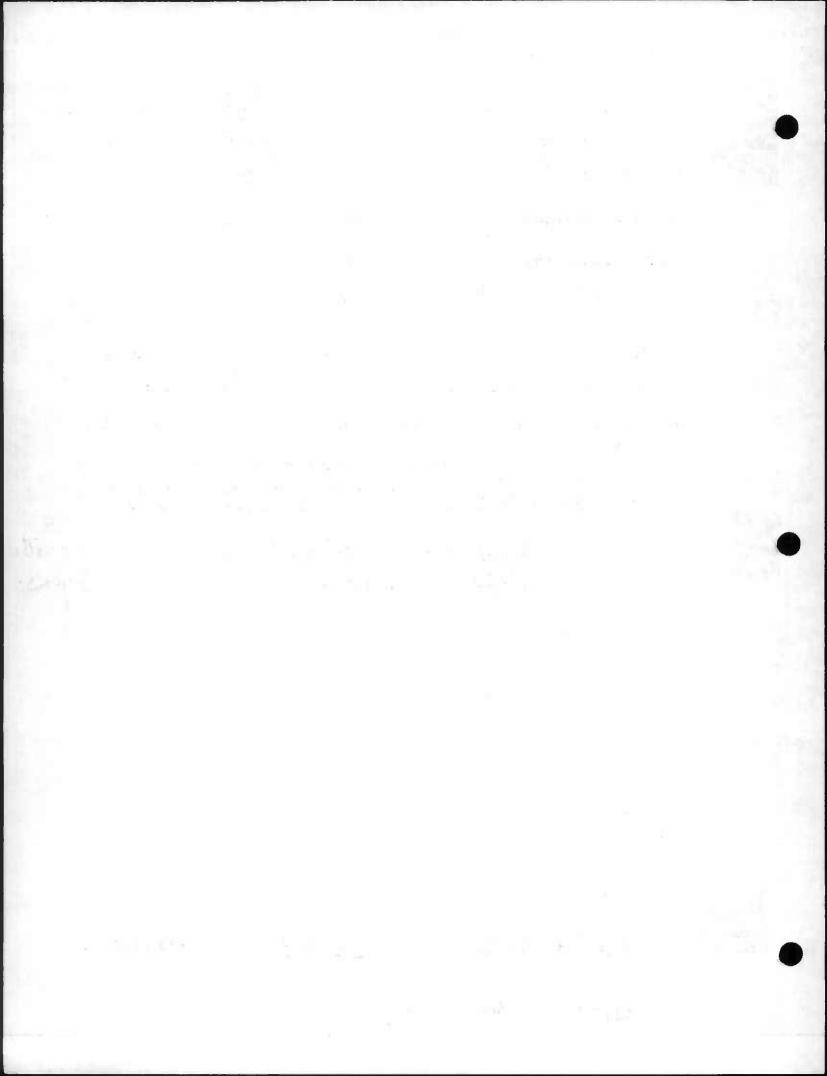
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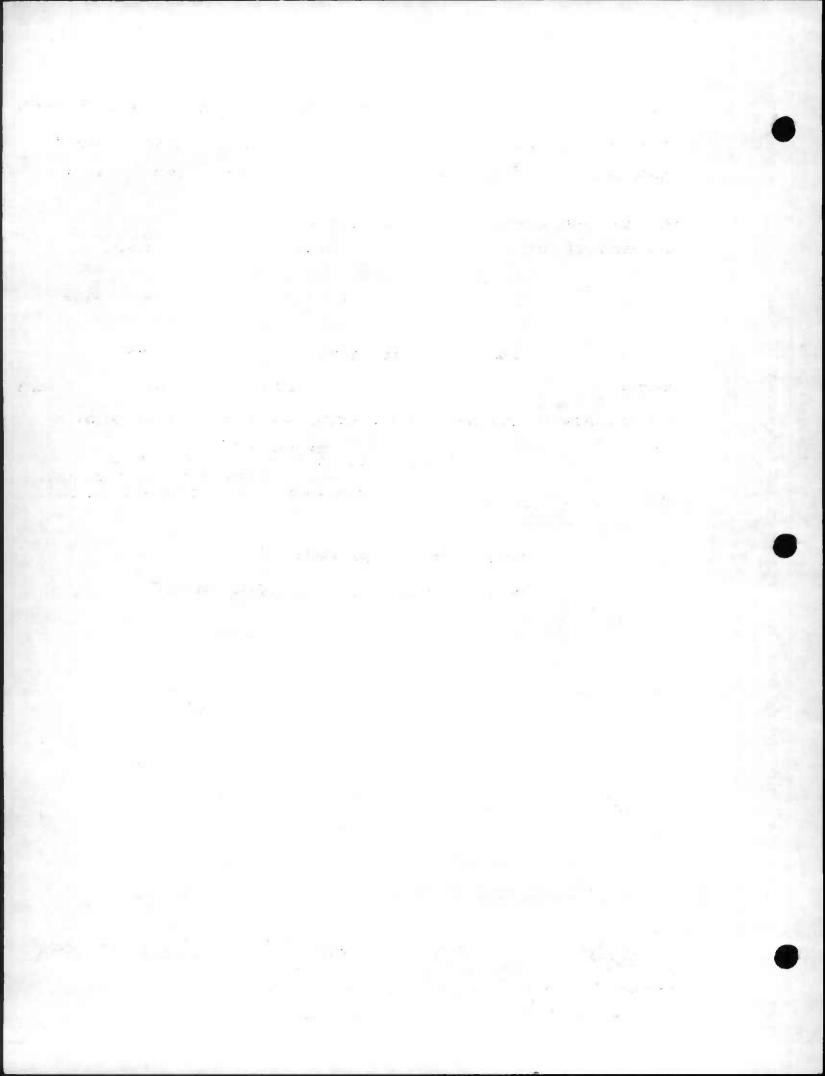
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Baltimore,	permit. Peges 1 end Department of Haalth Important: if Item 27 any Injury or other tr pnce.	21. Signature of Fu	ineral Service Li	censee	1		2. Name end Add		L HOME	P.A			
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Div	ertit	4  Homicide	determin	buil	ding, etc. (Speci	ty)	001, 1001019, 01110			y or Town			
Ŧ			CertifyIng	Phyeician: To th	ne best of my kno	owledge, deeth	n occurred et the	time, dete end	olece, end due	e to the ca	ause(s) end m	enner es s	leted.
	n 24 hot n 24 hot ne Fune plately fi	(Check only one)	2☐ Medical E	xaminer: On the end me	besis ot examina inner stated.	ation end/or in	vestigation, in my	opinion, deeth	occurred et th	ne time, de	ate end place,	end due to	the cause(s)
	To the within 2 To the compla		title of confiler	1/			29c. Lice	nse number		2	9d. Date signe	d (Month,	Dey, Year)
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 5:35 Pm ESTELLE PALMISANO TEAN 1998 August /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Glen Burnie Arunde1 North Arundel Hospital Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 F 71 Yrs. 2, 1926 DEC. MARYLAND Director 219-20-5876 Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Directo GLEN BURNIE MARYLAND ANNE ARUNDEL 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21060 1574 REINHARDT LANE U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No 14. Rece - American Indien, Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 3 ☐ No Specify: Yes Give Specify WHITE by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) SUGAR BOOKKEEPER 12 N/A 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be LOU WITTE KAILER **EMMA** FRANCIS 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Peges 1 end 2 s ment of Health en ant: If item 27 is r ury or other trau 1574 REINHARDT LANE, GLEN BURNIE, MD. 21060 ANTHONY PALMISANO (HUSBAND) 20b. Place of Disposition (Name of cametery, crematory or other PARM ETERY 8/20/98 20c. Location - City or Town, State 20e. Method of Disposition 1 X Burial 2 Cremation 3 Removel from State permit. Pege Depertment of Important: If any Injury or once. ODENTON, MD. EPIPHANY EPISCOPAL CHURCH 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 hael duan 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shook, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Final myocar of Ac disease or condition resulting in death) **Examiner** Primorany DISTAGE Examiner DBITCHUTTE b. UHRUMC physicien end the buriel-trensit certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) Physician/Medicai thet Initieted events resulting in death) Lest Due to (or as e consequence of): e s esn 20 23b. Did tobasto use contribute to the cause of death? ed by the deteched Pert II. Other elanificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 No 3 Probably 4 Unknown signed t þ 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy Completed completion of cause of deeth? has page 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes certificate funeral director, 25. Was cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpetient 3 DOA 1 Impatient After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? Certification: Natural 2 Accident 5 Pending efter deeth. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours e Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier edicai To the Hosp within 24 ho To the Fune completely f (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature end title of certifier 29c. License number angun NORTH ARUNDEL HOSPITAL Butmy Month, Day, Year) 31. Date filed State AUG 2 1 1998 Registrar

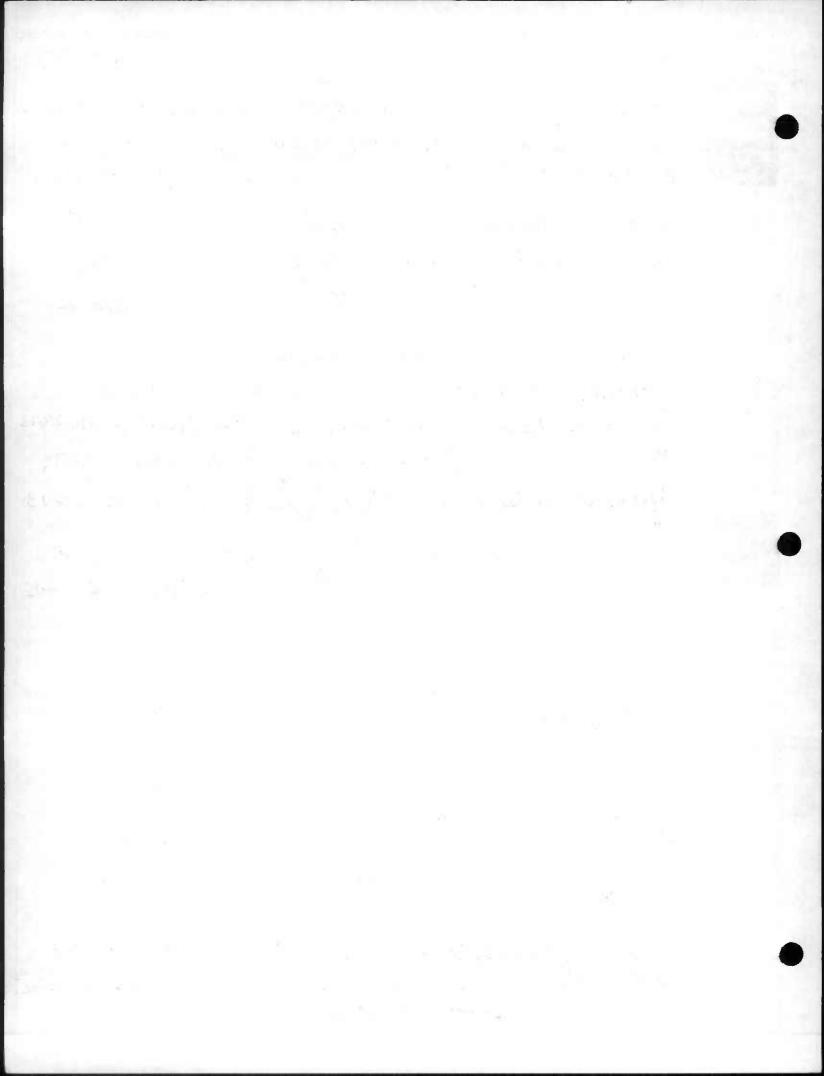


			State of Marylar	nd / Department of I			ene 9 (	26872
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	/ Months Devs		. (Month, Dey, Y	ear)	9. Birthplece (Stete or Foreign Country)
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dend wo		10e. Stete 10b. County	10c. Cit	y, Town or Location				10d. Inside Çity Llmits
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e La	Iner	11. Marital Stafus	<ol><li>Wes Decedent Ever in U Armed Forces?</li></ol>	.S. 13. Wes Decedent of I	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)		e - American Indien, ck, White, etc.
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permit. Pa Depertmen Important: any injury pnce.		21. Signature of Funerel Servica Licenses	~1	22. Name end Addre	ess of Feeility	1 HOME	P.A	
70 F 6 0		Janelle C.	Henry	510 Wash	ington			MD. 21613
		23a. Pafti. Enter the disease, or complicion shock, or heart feilure. List only one	ations that caused the dat ceuse on eech line.	h. Do not enter the mode of dyl	ng, such es cardia	c or respiretory erres	1.	Approximete Intervel Between
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	Physician/Me	Pert II. Other eignificant conditions contr		ulting in the underlying cause gi	ven In Pert I.	23b. Did tob	acco use co	ntribute to the cause of death?
law requires that the as been signed by the 32 should be detech		1 Lunest	ensean			1 🗆 Yes	2000	3 ☐ Probably 4 ☐ Unknown
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the Fu	edica	enel 2 Medical Examine	er: On the besis of exemine end menner stated.	tion end/or Investigation, in my	opinion, deeth occi	urred et the time, date	end pleca,	ena due to the ceuse(s)
Tor	Σ	29b. Signature and title of certifier		29c. Licens				d (Month, Dey, Year)
		Fin In	nuly p	D	10 99	17	8-	19-98 AMBRIDGE, M
	1	30. Name and eddress of person who com	pleted cause of death (Iten	23e) (Type, Print)	00 8	IRN .	7.	AMBRINE

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) AUG 2 4 1998



State of Maryland / Department of Health and Mental Hygiene

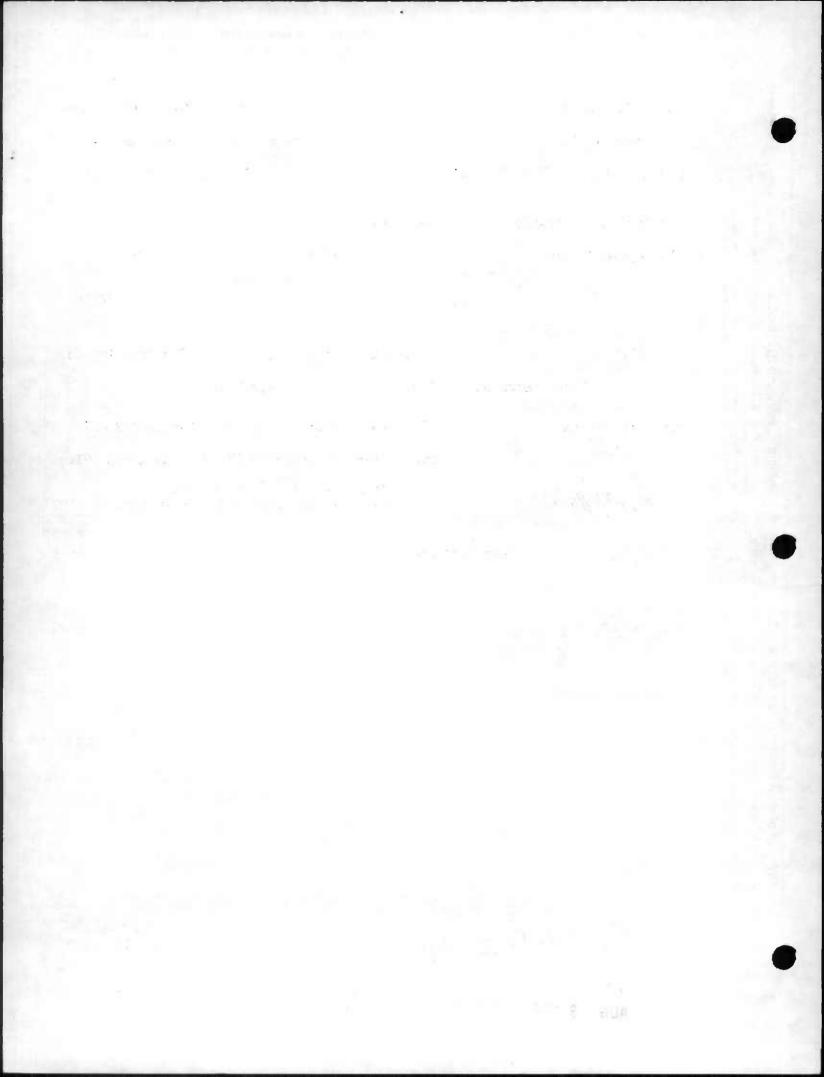
Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Dey **Physician** Franklin L. Raines August 16, 1998 1:00 A.M. /Medical 4c. County of Death 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer)

Jan. 23, 19 916 Edgewood Road Anne Arundel 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** 1√2 M 2□ F Yrs. 220-28-3912 65 Director 1933 Maryland Usual Residence of Decedent with the Marylen 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Expressional must be notified at 1∏Yes 2□No Directo Maryland Anne Arundel Edgewater 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Edgewood Road 21037 USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1∆DVes 2 □ No If Yes, Give Year or Dates: 1953–55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after and of Health and Mental Hygiena.
At: If Nem 27 Is marked other than "natural", or He 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) 12th College (1-4or 5+) Superintendent & V.P. Construction Co. 18. Mothar's Nama (First, Middla, Meiden Sumema) 17. Father's Neme (First, Middle, Last) Cephas Alexander Raines Ethel Reed 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Ann Raines, wife 916 Edgewood Road Edgewater, Maryland 21037 other t 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2XX remation 3 ☐ Removal from State permit. Pege Depertment o Important: If any injury or Metropolitan Crematory 8-17-98 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 2973 Solomons Island Rd, Edg 23a. Part1. Enter the disease, or complications that ceusad the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final Adenocarcinoma Lung 6 months disease or condition resulting in death) Examiner Dua to (or es e consequence of): Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last physician and the buriel-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) usa es ŏ the 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy Deen completion of ceuse of deeth? hes page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 20 No 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) n by 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner es stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certilier 29d. Date signed (Month, Dey, Year) 29c. Licansa number August 16, 1998 D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestgate Road Suite 300 Annapolis, Maryland 21401 E.W. Cole, M.D. 32 Spintry's Signature

DHMH 16 Rev 6/95

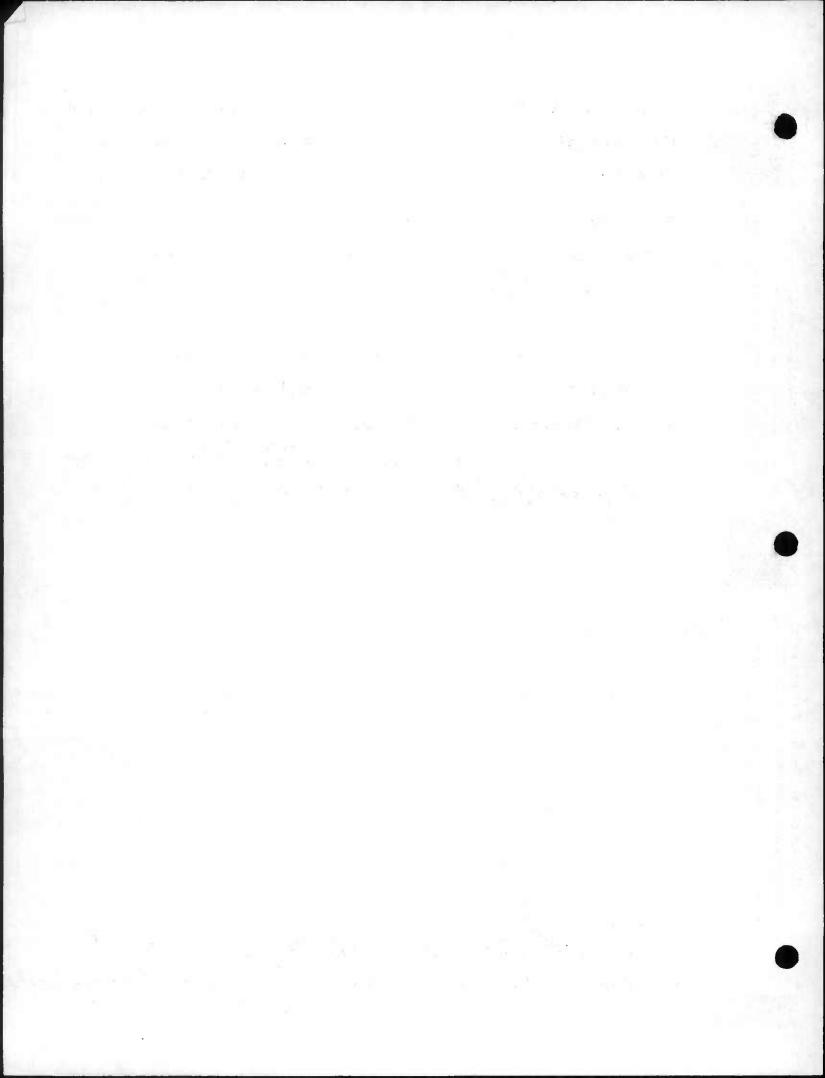
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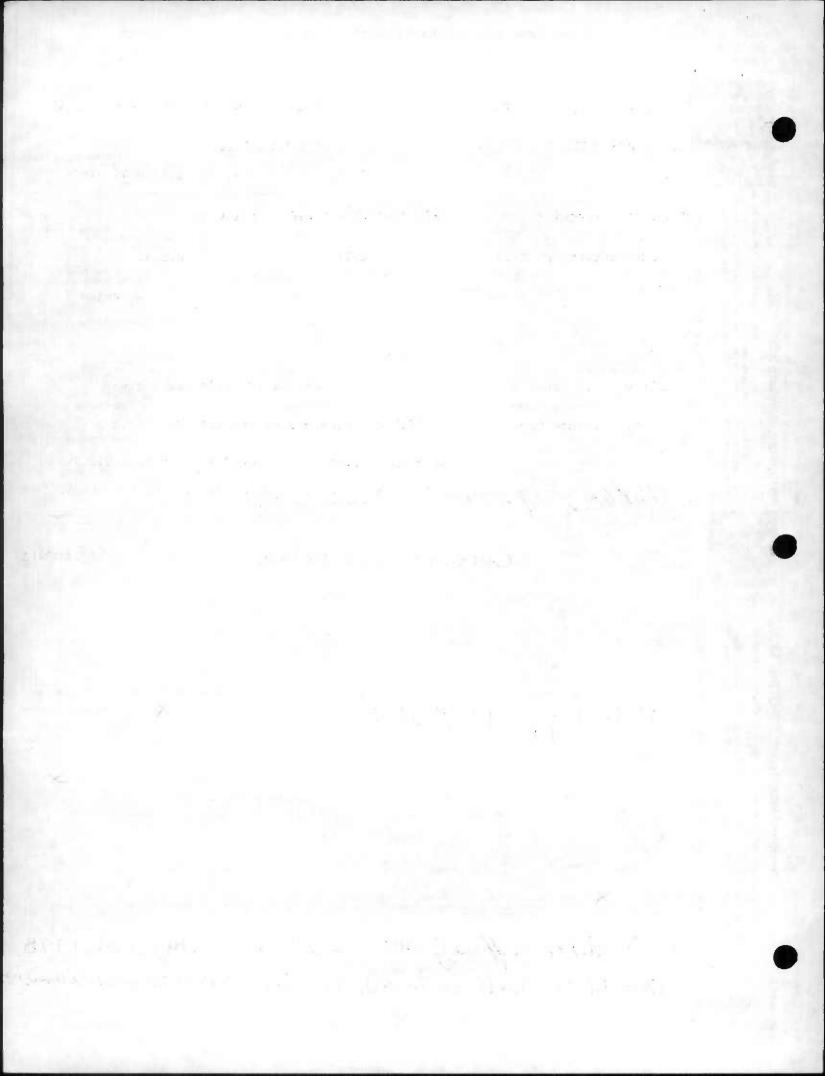
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

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	-	5. Social Security N			7. Age (In yrs.	last hirthday)	If Under 1 Yaer	If Undar 24 Hrs.	9 Date of B		n Anne's	40 as Fac
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28	Director	10e. Street and Nu			0.114		10f. Zip Code			10g. Citizan of	Whet Country?	
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n end Mer 7 is marke traumatic		19e. informent's N	eme/Ralationship	(Type, Print)		19b. Meillr	ng Address (Straet	end Number or Ru	ral Route Num	ber, City or Town	, Stete, Zip Code)	
realth em 27 i		Helen C	. Wallac	e/Wife		1739	Harbor	Drive, Ch	ester,			
Item 2		20e. Method of Dis	position Cremation 3		20b. F	Place of Dispo	stion (Nama of metory or other pla	Augus	t Date,	928 Location	- City or Town, Stet	1
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10c. Celly, Town or Location   10d. Inst.				IN SEAST		Yrs.	2   29		May 28,	1998		
106. Street end Number  3803 Rectortown Road  11. Martel Status  12. Was Depotent Ever in U.S.  11. Martel Status  12. Was Depotent Ever in U.S.  11. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  12. Was Depotent Ever in U.S.  13. Was Depotent Officer, Original Status  14. Was Depotent Ever in U.S.  15. Was Depotent Ever in U.S.  16. Repotent Ever in U.S.  17. Was Depotent Ever in U.S.  18. Was Depotent Officer, Original Status  19. Benerately Status  19. B					10c. City	, Town or Lo	cation				1	0d. Inside City L
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Content of the property of the completed of the property of		1 ☑ Never Married 2 N	larried	Armed Force 1 Yes 2 If Yes, Give	es? I <b>X</b> No				(Specify Yes or No erto Rican, etc.)	BI	ack, White,	etc.
Elementery/Secondary (0-12)   College (1-4or 5+)   Trible   None   Trible   None   Trible   None   Trible   None   Trible   None   Trible   None   None   Trible   None   Trible   None   None   Trible   None   Trible   None   Trible   None   Trible   None   None   Trible   None   None   Trible   None	1	15. Deced	ient's Edu	cation e completed)		16e. Deced	ent's Usuel Occi	upetion le during most of w	rorkina	16b. Kind of I	Business/In	dustry
18. Mother's Name (First, Middle, Last)   France Isabelle ter Weele	Е	Elementery/Secondary (0-12	1		or 5+)	life. L	OO NOT use retir	red)				
Jeffrey M. Wine   France Isabelle ter Weele	17		lio I ast)			nor	le	18 Mother's N	ame (First Middle		me)	
19a. Informent's Name/Reletionship (Type, Phin)  Jeffrey & France Wine  3803 Rectortown Road Marshall VA 20115  20b. Method of Disposition 15B Durial 2 Circemetor 3   Removal from Steet 4   Donestion 3   Removal from Steet 4   Donestion 5   Doher (Specify)  21. Signature of Fourier Library 1   Phin (Specify)  22. Name and Address of Fecility Moser Fruneral Home Inc. 233 Broadview A Warrenton VA 20186  23a. Part Library 1   Enter the disease, dromplications that caused find death. Do not enter the mode of dying, such as cerdiac or respiratory errest, in enter disease or condition resulting in death)  25b. Use to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  Due to (or es e consequence of):  25c. Wes sate referred to medical 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 2   No 1   Yes 2   No 1   Yes 2   No 2   No 2   No 2   No 3   Year of North (Road) 1   Yes 2   No 3   Year of North (Road) 1   Yes 2   No 3   Year of North (Road) 1   Yes 2   No 1   Yes 2   No 3   Year of North (Road) 1   Yes 2   No 4   Yes 2				2								
Jeffrey & France Wine   3803 Rectortown Road Marshall VA 20115	-	-	onship (Ty	pe, Pnint)		19b. Meilin	g Address (Stree					Code)
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### According to the response of Funeral Service Licenses  ### According to the response of Funeral Rome  ### According to the response of Funeral Rome  ### According to the Rome and Address of Foothly  ### Warrenton VA 20186  ### According to the Rome of Funeral Rome  ### According to the Rome of Rom	20a					leca of Dispo	sition (Name of		1		- City or To	own, Stete
Moser Funeral Home Inc. 233 Broadview A Warrenton VA 20186  23a Parti. Enter the disease, or complications that caused file deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, interventional interventional disease or condition resulting in death)  Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I.  Pert III. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I.  Pert III. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause. Enter Underlying cause referred to medical exeminer?  1 Yes No 3 Probably  24b. Wars an autopsy performed?  25c. Was case referred to medical exeminer?  1 Yes 2 No  27c. Menner of Deeth 1 Industry and 1 Indust				lemoval from Ste	ete ete				8/30/98	Marsh	all V:	irginia
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Immediate Cause (Finel disease or condition resulting in death)  Due to (or es e consequence of):  Due to (o	23	a Part. Enter the disease	, or compl Jst only or	ications that cau	sed the deeth	n. Do not enfo				rrest,		Approximete Intervel Between
Due to (or es e consequence of):  Sequentially list conditions, if eny, leading to immediate Cause (Disease or Injury the triniteded events resulting in deeth) Lest  Due to (or es e consequence of):  Due to (or												Onset end Dee
Due to (or es e consequence of):    Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying that initiated events resulting in deeth) Lest   Due to (or es e consequence of):	dis	ease or condition		Ce	reb	ral	ISC	hemiz	1		(	18 ha
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24e. Was an eutopsy performed?  24b. Were eutopsy performed?  25c. Wes case referred to medical exeminer?  1	Per	t II. Other eignificent cond	litions cor	tributing to deat	h but nof resu	ulting in the u	nderlying cause	given in Pert I.	23b. Dld	tobacco usa c	ontributa t	o the cause of c
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exeminer?    Yes   2   No	25	Wes case referred to med	ical					26 Place of F				_ 100 208410
27. Menner of Deeth   Neture    2   Accident   3   Suicide   4   Homicide     29a. Certifier (Check only one)   29b. Signeture end title of certifier     29b. Signeture end title of certifier     29b. Signeture end title of certifier     29b. Signeture end title of certifier     29c. License number     28c. Injury et Work?     1   Yes 2   No     28c. Injury et Work?     1   Yes 2   No     28d. Describe how injury occurred     28d. Describe how in		exeminer?		fospital:	atient 2	ER/Outpatien	t 3 DOA	Other:			ther (Speci	(y)
2 Accident 3 Suicide 4 Homicide 28e. Pleca of Injury - At home, farm, street, fectory, office 28f. Location (Street and Number or Rural Route City or Town, Stete)  29a. Certifler (Check only one)  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Dey, Ye.)	27.	1	odina			28b. Time of						
29a. Certifier (Check only one)  29b. Signeture and title of certifier 29c. At nome, farm, street, lectory, office 20c. Examines of North Annual Florida Flori		2 Accident inve	stigation				M 1	☐ Yes 2☐ No				
29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es stated.  2 Madicat Examiner: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ce and manner stated.  29b. Signeture end title of certifier  29c. License number  29d. Dete signed (Month, Dey, Ye		date	emined	28e. Pleca of building,	Injury - At ho , etc. (Specify	ome, farm, str	eet, fectory, offic	8			nber or Run	al Route Number
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Donald It Shad ( as To MI) The Johns Hopkins Hospital Bo	30.	Name end eddress of pers	on who co	mpleted cause of	or deeth (Men	7 N	D 77	Le Toh	ns Nople	is Hos	nila	1 Balto

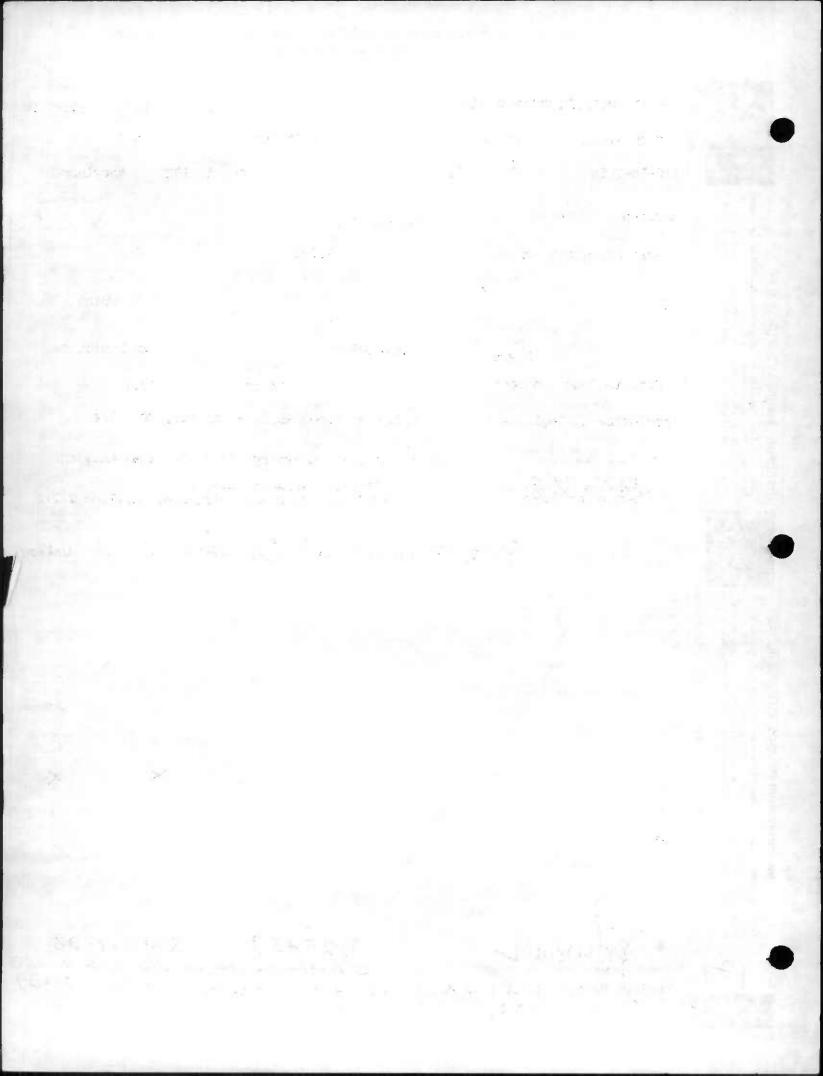


State of Maryland / Department of Health and Mental Hygiene

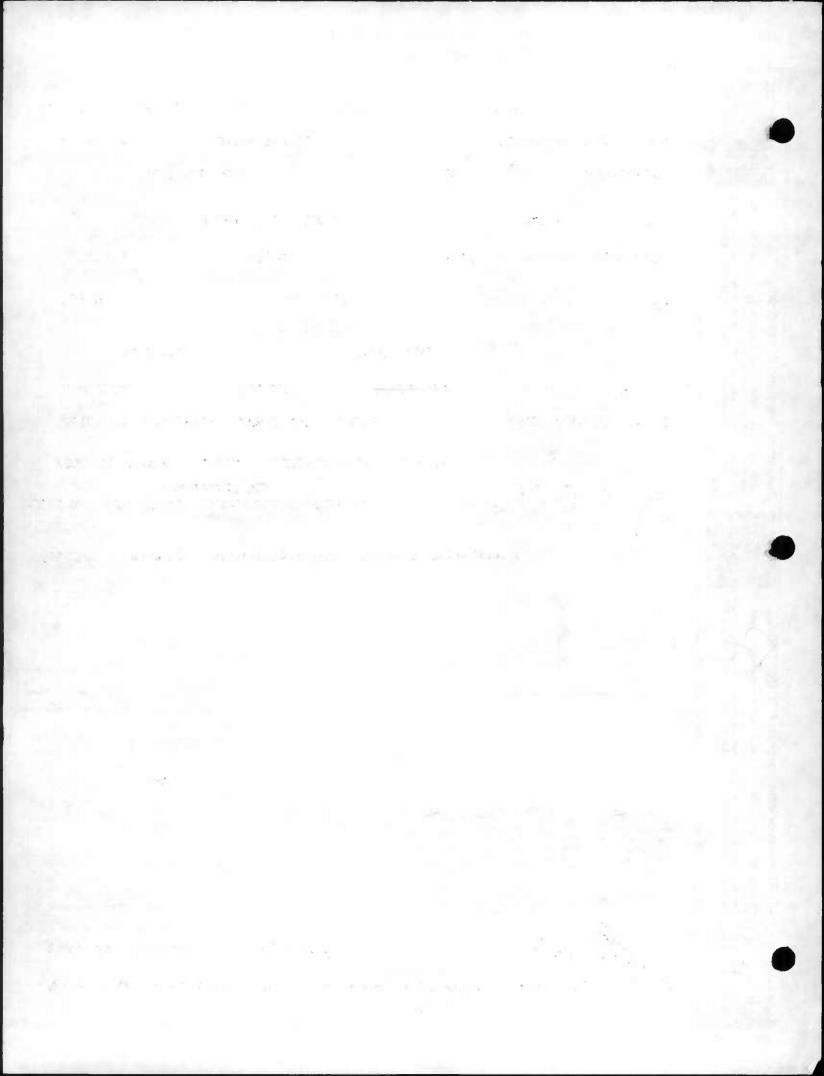
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** RITA ROSALIE ROBERTS ALESSI August 30, 1998 11:42 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GOOD SAMARITAN HOSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 10M 2F Yrs. 216-14-7053 76 Aug 19 1922 Maryland **Director** Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Maryland N/A Yos 2 No Director Baltimore City 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? with 21206 IISA 3714 Evergreen Avenue filed within 72 hours after death v Hygiane. Ither than "natural", or Items 23 Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Reca - American Indien, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ White 3
☑ Widowed 4 □ Divorced Completed 16e. Decadent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondery (0-12) Own Residence Homemaker Pages 1 end 2 should be filed w ment of Heelth and Mentel Hygiai lant: if item 27 is marked other th jury or other traumatic event, to 2 yrs 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Francis Adam Roberts Gall Helen 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 1826 Glen Ridge Road, Baltimore, MD 21234 Antoinette K. Saglimbeni 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Dependent of Important: If any Injury or once. Gardens of Faith Cemetery9/3/98 Overlea, Maryland 21. Signature of Funeral Service Uncharged

Martin D. Lawson 22. Name and Address of Fecility Altenburg Funeral Home, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** nosderatic Cardiovasular Disease /Medical tmmediate Cause (Finel diseese or condition resulting in death) Examiner Examiner physician and the bunel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 USB signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy s certificate hes b 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? director. Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Manger of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Neturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) in 24 hour.
The Funeral Direction of Filled in by 6 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 290. Signature and fitted certifier Sep 2, 1998 D25753 of person who completed cause of deeth (Item 23e) (Type, Print) J. Andrew Sumner, MD, 5601 Loch Raven B. Martin. M.D. 7672 Relair Poad. Raltimore Maryland Buttimore 21239 Michael Martin, M.D., 7672 Belair Road, Baltimore, Maryland 31. Dete line Month Day 32. Registrer's Signature State Registrar



	Film G763 9-3-98RC	Certif	ficate of i	Death		Reg. No.	1	2 Time of Pt
ian ical	Decedent's Name (First, Middle, Last)     REBECCA SARA	A	XELROD		2. Date of De Month AUGUST	Day 199	Year	3. Time of Deeth 9:17 AM
er	4e Fecility Name (If not institution, give street and number)		4	b. City, Town, or Lo	cation of Death	4c. County	of Death	
	NORTHWEST HOSPITAL CENTER			RANDALLS			BALTI	
	063-07-5220 1□M 2XF 8:	N	f Under 1 Year lonths Days	Hours Min.	8. Date of Bird (Month, Da OCT 23	th y, Year) B, 1915	9. Birthplac Country	ce (Stete or Foreign v) NY
	Usual Residence of Decedent  10s. State 10b. County 10c.	. City, Town or Locati	ion				10d	d. Inside City Limits
	FL DADE		NO	RTH MIAMI	BEACH			1 Yes 2 □ No
1	10e. Street and Number		10f. Zip Code			10g. Citizen of W	/hat Country	y?
The second second	100 KINGS POINT DRIVE #11:	19		33160			U.S.A	Δ .
	11. Marital Status  1 □ Never Married  1 □ Never Married  2 □ Married  3 □ Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cuba	lispanic Origin? (Spe an, Mexicen, Puerto I Specify:	cify Yes or No Rican, etc.)	14. Race Blace Specify:	- American k, White, etc	n Indien,
	15. Decedent's Education	16a. Deceden	t's Usual Occup	ation		16b. Kind of Bu	siness/Indu	stry
	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	HOMEMAK	d of work done of NOT use retired	during most of working)	ng	OWN HO	ME	
	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,	Maiden Sumem	e)	
	SAM FABRICANT	FABRICANA		MOLLI	Е		FRIE	DMAN
1	19a. Informant's Name/Relationship (Type, Print)			end Number or Rure				
	LESLIE AXELROD (SON)			EIGHTS WA		LTIMORE,		21209
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removet from State	Ob. Place of Disposition cometery, cremeter OLD MONTER	ory or other place		Date 1/2/98	20c. Location -	Maria.	
	21. Signature of Funeral Service Licensee  21. Enter the disease, or complications the eaused the caused the caused the cause on each line.	8		SOL	ROAD		ILLE,	INC. MD 21208 Approximate nterval Between Onset end Death
	resulting in deeth)	to (or es e conseque		MD10V15	wim	DISENS	5 (	YEARS
	if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.	to (or as e consequer						
	d				oor Did			the cause of death
	Part II. Other significant conditions contributing to death but not	t resulting in the unde	inying ceuse gr	ven in Part I.		Yes 2□ No	3 Proba	
						an autopsy ormed?	com	e autopsy findings lable prior to pletion of cause seth?
					10	Yes 2000	10	Yes 2□ No
e combiered	25. Wes cese referred to medicet			26. Plece of Deeth				
To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2/25 EP/Outpatient	3 DOA Oth	or		idence 6 Othe	er (Specify)	
Certification:	27. Manner of Death  1 Naturat  2 Accident  3 Suicide  28a. Date of Injury (Month, Dey Yea			Yes 2□No		how Injury occurr		Quita Number
Cerm	4 Homicide determined 28e. Place of Injury - building, etc. (Sp.	oecify)	, ractory, office		City or To		or or ridror	, route rustiper,
60	29a. Certifier (Check only one)  DECCrtifying Physician: To the best of my 2 Medical Examiner: On the basis of examend manner stated.	knowledge, death or mination and/or inves	ccurred at the tir tigation, in my c	me, date and place, opinion, death occurr	and due to the ed at the time,	ceuse(s) and ma date and place, a	inner es ste and due to t	ited. the ceuse(s)
edical			OOn Linne	se number		29d. Dete signe	d (Month, D	ey, Year)
	29b. Signature and the of certifier		29C. Licens					
Medic	29b. Signature and the signatu		P4	758)		AUGUST	- 31.	1998



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 98-26878 Replacement Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath **Physician** 1:51 AM august onald /Medical 4a. Facility Nama (If not institution, give straet and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 08 Mary land Medical System NA University Paltimore If Undar 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar)
Nov 6, 1954 5. Social Sacurity Number Birthplaca (State or Foreign Country) **Funeral** 1₹M 2□ F 43 Yrs. 215-68-4320 MD Director Usual Residenca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3514 Meadowside Road 21207 United States items 23e Funeral 12. Was Decadant Evar in U,S. Armad Forcas? 1≦ Yas 2☐ No If Yas, Giva Yaar or Dates: 74 – 78 Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 72 hours efter 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yas 2 Ho Specify: Specify: Black by 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Warehouse Hygiene. Elamentary/Secondary (0-12) College (1-4or 5+) Stock Clerk other 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be h end Mental I WT Aye Grace Taylor 19a. Informant's Name/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 end 2:
Depertment of Health er
Important: If Item 27 is
eny Injury or other trau Mrs. Cherryl Aye (Wife) 3514 Meadowside Road, Baltimore, MD 21207 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Sep 8 1 Burial 2 Crametion 3 Ramoval from State 1998 Owings Mills, MD 4 ☐ Donetion 5 ☐ Othar (Spacify) Garrison Forrest V. A. 22. Nama and Addrass of Facility
Calvin L Williams Funeral Service 21. Signatura of Funaral Sarvica Licensaa lear 270 Fredhilton Pass Baltimore, MD 23e. Pert1. Entar tha disaase, or complications that caused tha daath. Do not anter the mode of dying, such es cardiac or raspiretory errest, shock, or haart failura. List only ona causa on aach lina. Approximata Intarvel Between Onsat and Daath **Physician** /Medical Immediate Causa (Final diseesa or condition rasulting in daath) unknown Examiner Examiner otension unknown physician end s the buriel-transit Sequantially list conditions, if any, leading to immediate causa. Enter Undarlying Causa (Disaasa or injury that initieted events rasulting In death) Last Spiration Unknown Box 68760 Completed, by Physician/Medical Dua to (or as a consequence of): for use es Part II. Other algnificent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Disease, Insulin Dependent 24b. Wara autopsy findings evaileble prior to complation of ceuse of death? 24a. Was an autopsy performad? Chronic Renal Failure pege 2: 2 No 1 ☐ Yas > No Hospital or Attanding Physician: 25. Was cese referred to medical examinar? Be 26. Piece of Death (Check only ona) 1 1X Yes 2 No Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Minpatiant 2□ER/Outpatient 3□ DOA Certification: To 27. Manner of Deeth 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Dey Year) 28c. fnjury at Work? After 1 Natural 5 Panding Invastigation efter death.

Director: After din by the fundament 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Straet and Number or Rurel Route Number, City or Town, Stata) 3 ☐ Suicida 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicida To the Hospital or within 24 hours aft To the Funerel Di completely filled in Medical 29a. Cartifian 🗷 Certifying Phyafcfan: To tha best of my knowledge, deeth occurred et the tima, data end place, and dua to the cause(s) end menner es stated. (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature end titla of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year)

Greene Street Baltimore, Hd 21201

DHMH 16 Rev 6/95

State

Registrar

30. Nama and addrass of person who complated ceuse of death (Itam 23a) (Type, Print)

MD

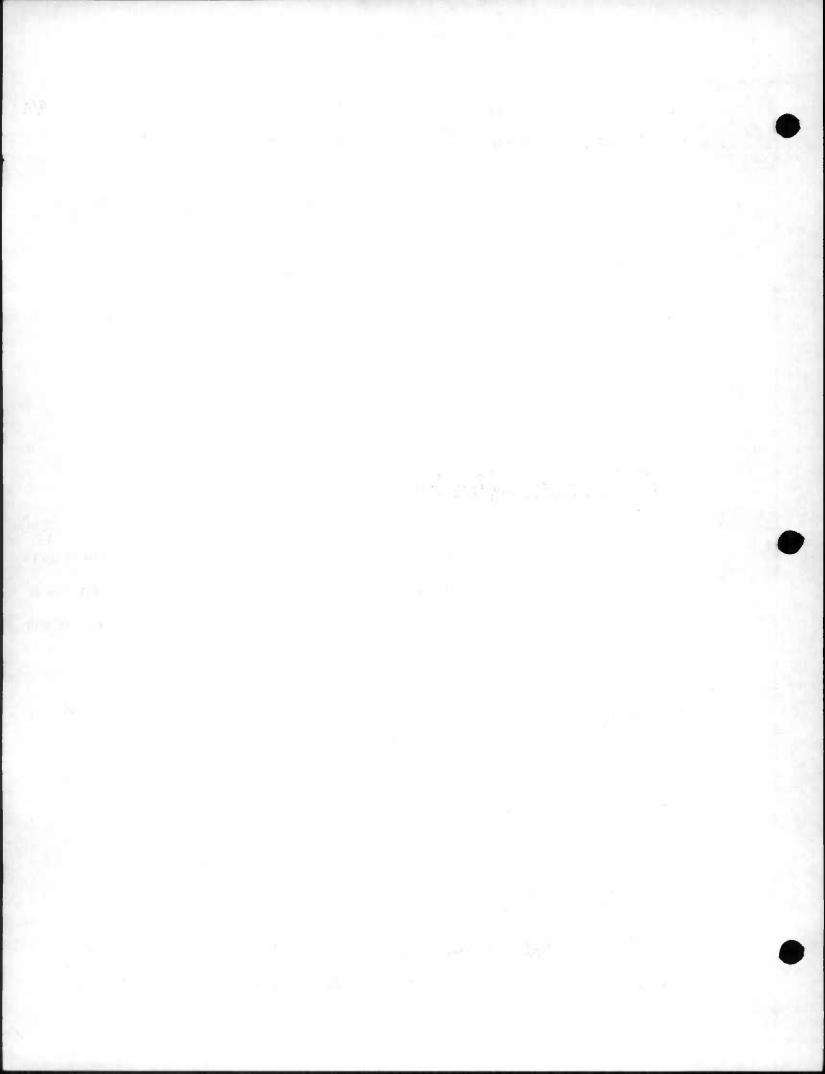
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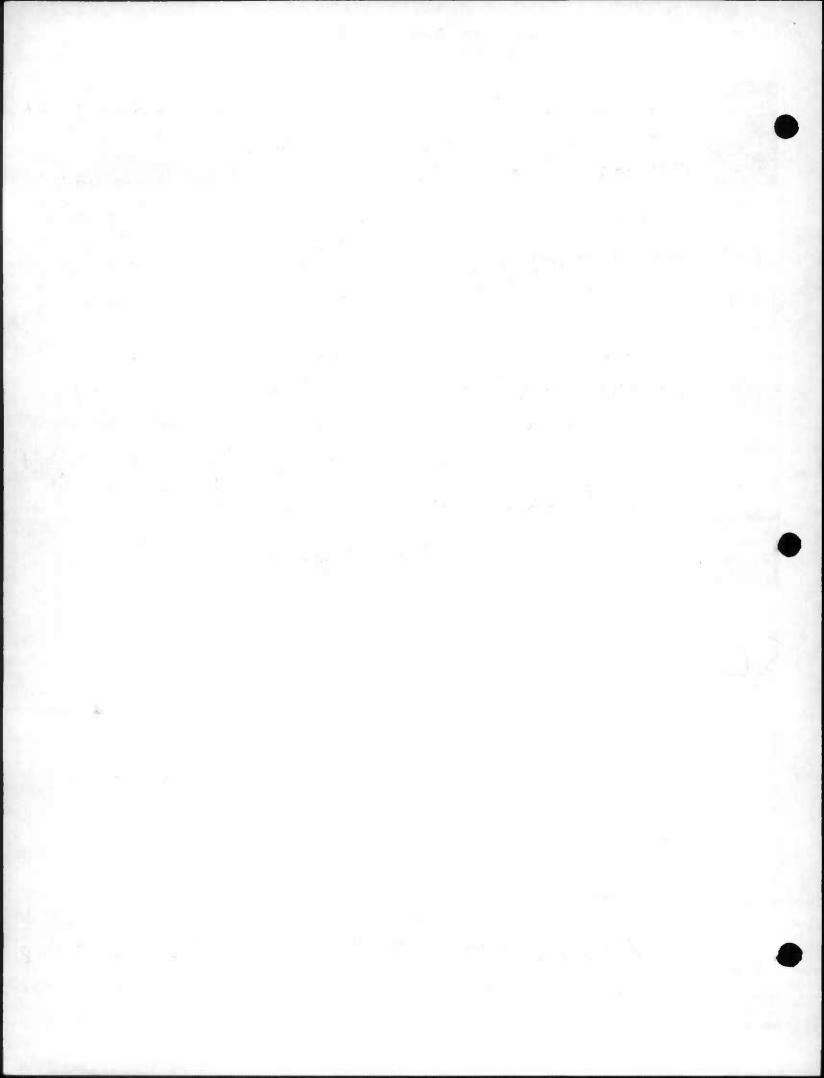
1998

31. Data filad (Month, Day, Year)



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 6879 State of Maryland / Department of Health and Mental Hygiene

	_			Contino	ate of Death	F	leg. No.		
Physiciar	n	1. Decedent's Nama (First, Middla,	0			2. Date of Dea Month	th Day	Year 3.	Time of Dea
/Medica	_	Leona	13 Bluna	~		SEPTE			00:2
Examine	r	4a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death	4c. County	of Death	
			AMIAN Ita	13P11AL	BALA	o, Mi).			
uneral		5. Social Security Number	7. Aga (In yrs. 1 ☐ M 2 ☐ F	Yrs. Mont	hs Days Hours Mi		Year	9. Birthpiace (Country)	(State or Fo
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show	1	10a. State 10b. County	10c. Cit	ty, Town or Location		·		10d. Ir	nside City Li
100	ō	Maguland	B	allemas	0				Yes 2
notified	Director	10e. Street and Number		101.	Zip Code	1	0g. Citizen of V	What Country?	
23a or	2	Walo Bunny	011/1/01/		21205		110	34	
herma ner ma	Funeral	11. Marital Status	12. Was Decedent Ever in U	,S. 13. Was De	ecedant of Hispanic Origin? (specify Cuban, Mexicen, Pue	(Specify Yes or No-		e - Americen In	dlan,
		1 Never Marriad 2 Married	Armed Forces?			nto Rican, etc.)	Blac	ck, White, etc.	
- 2	D	3 ☐ Widowad 4 ☐ Divorced	If Yes, Giva Year or Dates:	1LI Yes	s 2 No Specify:		Specify	Which	0
lical lical	Completed	15. Decedent's (Specify only highast)		16a. Decedent's U	Isual Occupation	vartin a	16b. Kind of Bu	usiness/industry	У
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them 27 is marked other other traumatic event,	o n	17. Father's Name (First, Middle, La	ist)		18. Mothar's N	ame (First, Middle,	Maidan Sumam	18)	
atic T	0 20	Andrew L	490MOSKLE		Kar	u Ju	antke	JUJK	V
E E		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addr	ress (Street and Number or I	Rural Route Numbe	City or Town,	State, Zip Code	θ)
m 27 her t	-	MIChael DIa	nar	11100 13	unburyw	ay Day	HMOR	D. Md	2120
9= M		20a. Method of Disposition  1 Suriai 2 ☐ Cremation 3		Place of Disposition ( cometery, crematory)	Name of or other place)	Soot 5	20c. Location -	City or Town, S	State
ury		4 ☐ Donetion 5 ☐ Other (Spe		ekwood	Cometer	1998	Parkvii	He. Me	apula
important: any injury once.		21. Signature of Funaral Service Lic	censee	22. Nama	and Address of Facility	Chanel S	W COOS	not no	o Pd
5 6 6		001949	1 (1.)000	2 LVW	to rupulkar	14 MARI	Med	2133	1
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edical miner		fmmediata Ceuse (Final disaasa or condition resulting In death)	a. Due to (c	Co-Ci or as a consequence	Segres			Ons	et and Dea
iclan end survival transit source transit source transit source transit source transits and the survival transits and tran	edica	disaasa or condition	b Due to (c	or as a consequence or as a consequence or	phone			Ons	et and Dea
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State of Maryland / Department of Health and Mental Hygiene

				Cer	tificate	ט זכ	eatn			Reg. No.			
Physician /Medical	1. Decedant's Nama (First, Middla, Cecelia Frances	Bielat (B							2. Data of De Month Septem	ber 2	Yaar 1998	3. Tima of Death 6:00 PM	
Examiner	4a Facility Nama (If not Institution,  Cromwell Nursin		ar)				. City, Tov Balti		ocation of Daat		y of Death <b>imor</b> e		
Funeral Director	213-92-3786	6. Sax 1 M 2 F 7.	Aga (In yrs. las	Yrs.	If Under 1 Y Months D	aar	If Under : Hours	Min.	8. Date of Bir (Month, De March	th ly, Yaar) 20 1913	9. Birthy Cour Mary	place (State or Foreign ntry) Land	
the Mentand 284-f show notified at	Usual Rasidance of Decedant 10a. Sfata 10b. County  Maryland Baltim	ore		c. City, Town or Location <b>Caltimore</b>								10d. Inside City Limits 1 ☐ Yas 2 No	
or 28	10e. Street and Number				10f. Zip Co					10g. Citizan of			
23s or	8710 Emge Road	#11B			2123	-				United			
5-0020 72 hours after death with the Meryland netural; or items 23s or 28s-f show less Exertine must be notified a steel by Funeral Director		12. Was Deceda Armad Force 1 Yas 2 ff Yes, Giva Yaar or Data	No No		<ol> <li>Was Decedant of Hispanic Origin? (Specify Yas or If Yas, specify Cuban, Maxican, Puarto Ricen, atc.)</li> <li>Yas 2 No Specify:</li> </ol>					No- 14. Race - Americen Indian, Biack, White, atc.  Specify: White			
T2 hours "natural", added by	15. Decedant's (Specify only highast	Education grada completed)		16a. Daced (Giva	ent's Usual O kind of work d OO NOT use n	ccupati ona du	tion uring most	t of work	ing	16b. Kind of E	Businass/In	dustry	
	Elamantary/Sacondary (0-12) Unknown	Coilaga (1-4c	or 5+)	None None	OO NOT use n					(hosp:		zed)	
re, Maryland 212 s 1 and 2 should be filed withi f Health and Mental Hygiene. fem 27 is marked other than other traumatic event, trait To Be Comp	17. Fathar's Nama (First, Middla, L John Leon Biela						18. Motha  Eva	ar's Nam		, Maidan Surna siazeck	ma)		
Te, Mar. 1 and 2 sho Health end em 27 is m	19a. Informant's Name/Relationsh Chester Blusiew		n-Law		g Addrass (Si Dudley					er, City or Town		o Coda)	
altimore, mit. Pages 1 ar pertment of Hea portant: If Item ? y Injury or othe £6.	20a. Mathod of Disposition  1 X Burial 2 ☐ Cramation  4 ☐ Donation 5 ☐ Other (Sp	sition (Nama on atory or other laus	place)	Cemetery 9-5-98			20c. Location - City or Town, Stata  Baltimore, MD						
Baltimor	Mitchel Mitchel							Addrass of Facility Ll-Wiedefeld Home, Inc. ork Road Baltimore, MD 21212					
Physician /Medical Examiner	23a. Pert1. Enter the disease, or o shock, or heart fellure. List of the shock of t		tas ta		Beea					rrast,		Approximata Interval Between Onset end Death	
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P.O. Bo thet the death of ed by the etten detached for u	Part II. Other significant conditions contributing to death but not resulting in the underlying cau						n In Part i	i.		tobacco usa c	ontribute t	to the cause of death	
In Records, P.O. Bo The law requires that the death sale has been signed by the etten page 2 should be detached for u Completed by Physician	Cerebrova	scular c	acide	ent					24a. Was	an autopsy	24b. W	/ara autopsy findings	
of Vital Records, Physician: The law requires this certificate has been signeral director, page 2 should be used. To Be Completed by								+		ormed?	of	vailable prior to omplation of ceusa i death?	
Vital Rician: The history page he rector, page										Yas 2 No	1	Yas 2 No	
Of Vita Physician: this certific ral director,	25. Was cesa rafarred to madical axaminar?  1 Yas 2 No	Hospital:		R/Outpatien	t 3□ DOA	Othar			th (Check only	ona) idance 6 □O	bas (Casa	26.1	
Sing After fune		28e. Data of la (Month, lation of ba	njury 2 Day Yaar) 2 Injury - At hom	8b. Tima of Injury	28c.				28d. Dascribe	how injury occi	urred	ral Routa Numbar,	
Division  To the Hospital or Attention within 24 hours after deat to the Funeral Director: completely filled in by the	29a. Certifiar Certifying (Check only 2 Medical E	Physician: To the be xaminar: On the basis							and dua to the	ceusa(s) end r			
To the H within 24 complete		Saguh		di		cansa	number			29d. Data sign			
7	30. Name and address of person		of deeth (Itam 2			i i	Balti	imor	e, MD 2	1133			
State Registrar	31. Data filed (Month, Day, Year)	32. Regi	istrar's Signatu		1	Ks							

Territory and the second section of the section of the sec MANAGEMENT OF STREET C 4 1 1 1 2 1 This is a second with a beginning and a substitute over 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 2 0110 A PAMELA E. BARCZAK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner GILCHRIST CENTER TOWSON BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Months 1 M 2 F 07-17-1950 Director 216-56-6833 48 NEW JERSEY Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Madical Examinat must be notified at 1 No Yes 2 No N/A BALTIMORE MD Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3917 Keswick Rd. 21211 USA Funeral AMELA ANN BARCZA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE nd Mental Hygiene. marked other than "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3YRS MEDICAL SECRETARY SECRETARY aith end Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Pages 1 and 2 should be ment of Health end Menta ant: If Item 27 is marked lury or other traumatic ev JULE TRELEASE JAMES A. EMERY JR. 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 139 EAST 94TH ST. APT. 7D N.Y., N.Y. 10128. SALLY EMERY (SISTER) 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, cremetory or other place) 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Depertment of Important: If any injury or page. 09/05/98 OXFORD, MD. 4 ☐ Donation 5 ☐ Other (Specify) OXFORD CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. lavoll wellam. 4905 YORK RD. BALTO., MD. 21212. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** metas tatic Small cell concer, probably I much Immediate Cause (Final disease or condition resulting in death) /Medical Examiner pAnciers Examiner tron physician end the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sion of Vital Records. by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy Completed H 1 ☐ Yes No 1 ☐ Yes 2 ☐ No certificate Physician 25. Was cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 결 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Descrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 200. Signature and this of certifi 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. C. (27 GBMC 6701 IX. C. 6701 H. Charles St. Balto. and 2,204 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

Registrar

SEP 0 3 1998

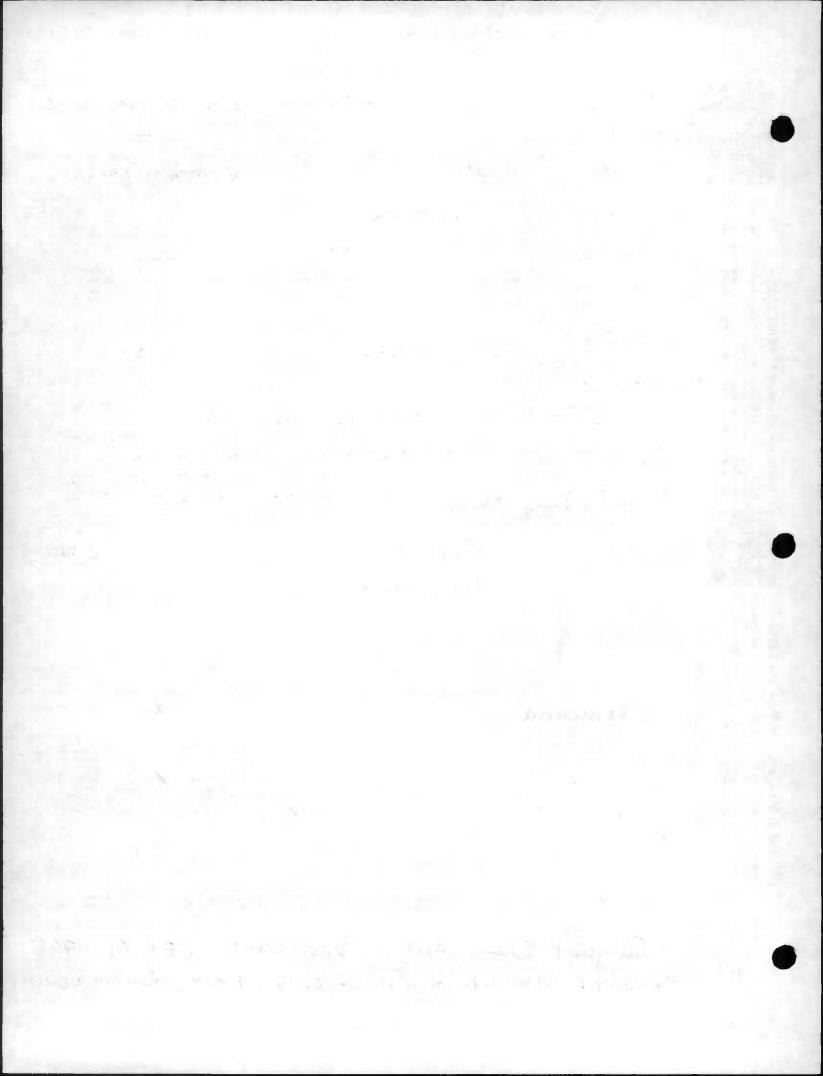
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BROWN MARY 1730 AU GR 31 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LORIEN NURSING HOME COLUMBIA HOWARD 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 2 F Months Days Hours 213-74-1376 Yrs. 94 Director 6/15/1904 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Counts 10d. Inside City Limits th and Mental hygiene. 7 is marked other than "natural", or hams 23s or 28s-f show traumstic evant, the Medical Examinet must be notified at BALTIMORE MD CATONSVILLE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 DUNVAGEN ROAD U.S.A. 21228 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 should be filed within 72 hours after on and Mental Hygiene.
Is marked other than "natural", or har 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE g 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) THOMAS B. LONG EDITH BERRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: if Itam 27 is m any Injury or other traum once. 720 STREAKER ROAD, SYKESVILLE, MD 21784 JAMES DONALD BROWN SON 20b. Place of Disposition (Name of cametery, crematory or other placa)
WOODLAWN CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 9/3/98 WOODLAWN, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WITZKE FUNERAL HOMES, INC. Robert 1630 EDMONDSON AVE, CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Sepsis /Medical Immediate Cause (Finel 2. Weeks disease or conditio resulting in death) Examiner rneumoura Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 88 use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 s 1 Yes 1 Yes 2 No certificate or Attending Physician: director, 25. Was case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Desth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred at the time, date end placa, end due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier D0052440 SEP OI SLOW, MD 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

SANTAY P. SHAH, MD 10805 HICKONY Ridge Rd. #210, Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 3 1998 Registrar

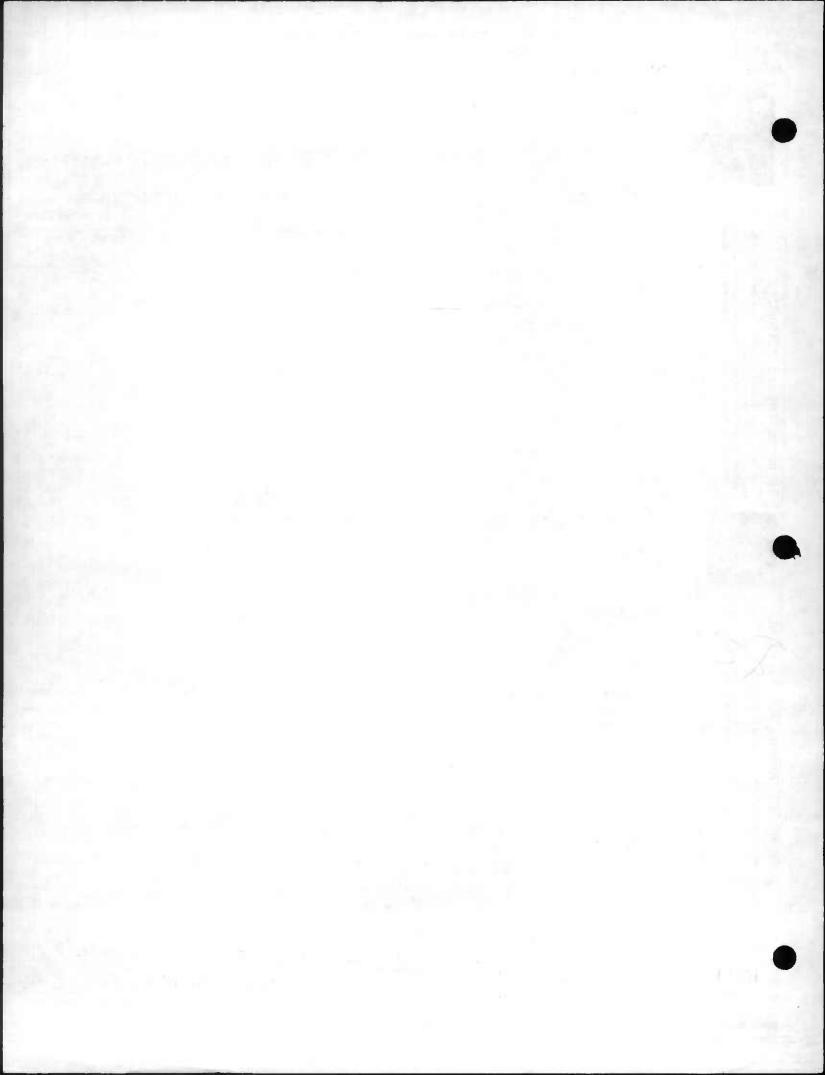


State of Maryland / Department of Health and Mental Hygiene

Amend: #12 Per FH Film G763 9-10-98RC Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death **Physician** 25th, 1998 10:40 A.M. AUGUST BL AND HARRY STEWART /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner 5716 PARKWAY DRIVE LAUREL. MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax XX M 2□ F 8. Date of Birth (Month, Day, Year) NOV. 28, 1928 9. Birthpleca (Stete or Foraign 7. Aga (In vrs. last birthday) **Funeral** Months Days Hours VIRGINIA 69 Yrs. Director 579-30-4947 Usual Rasidance of Dacedani with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f show 1 ☐ Yes XX No Directo MARYLAND MONTGOMERY LAUREL 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20707 5716 PARKWAY DRIVE U.S.A. Pages 1 and 2 should be filed within 72 hours after death viner of Health and Mental Hygiene.

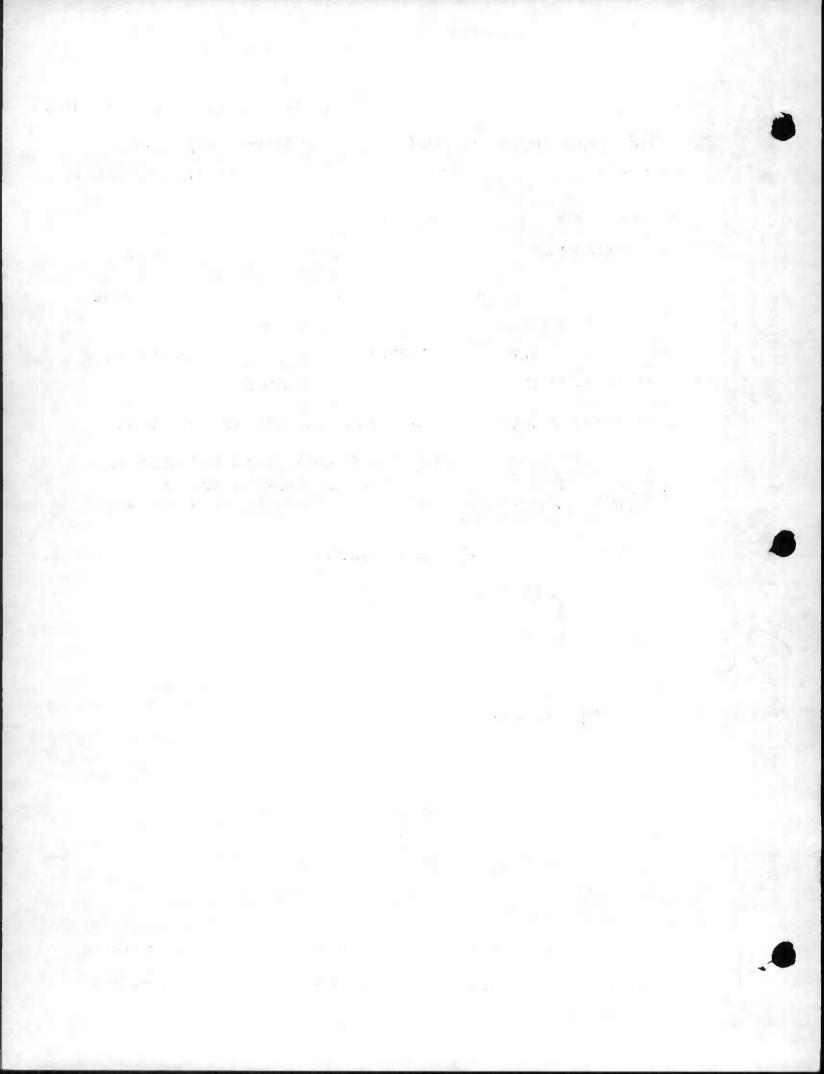
Int. It learn 27 Is marked other than "natural", or items 23 my or other traumatic event, the Natural Examine man Funeral 12. Wes Dacedent Ever In U.S. Armed Forces? 1946 – XX Yas 2 □ No It Yas, Giva 1957 Yaar or Detas: 1952 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Rican, etc.) 14, Race - Amaricen Indian. 11. Merital Status Black, Whita, atc. 1 Navar Married XX Married Specify: WHITE 1 Yas XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) MANAGER AUTOMOBILE DEALERSHIP 12th 18. Mother's Name (First, Middla, Maidan Sumeme) 17. Fathar's Nama (First, Middla, Last) EDWARD BLAND MARGARET WADE 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Intorment's Name/Ralationship (Type, Print) JOANNE R. BLAND (WIFE) 5716 PARKWAY DRIVE LAUREL MARYLAND 20707 20b. Place of Disposition (Name of cematary, cramatory or other place) AUG. 20c. Location - City or Town, Stata 20a. Mathod of Disposition important if its any injury or oth XX Buriel 2 Cramation 3 Ramoval from Stata 1998 SILVER SPRING MARYLAND GATE OF HEAVEN CEMETERY 4 Donation 3 □ Other (Specify) 22. Nama and Addrass of Facility HINES-RINALDI FUNERAL HOME, 21. Signature of Funeral Service Line 11800 NEW HAMPSHIRE AVENUE SILVER SPRING MARYLAND 20904-289 SILVER SPRIN

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath Physician Immediate Ceuse (Finel disaasa or condition rasulting in daath) /Medical a LUNG CANCER, NON SMALL CELL 1 MONTH Examiner Dua to (or es e consequence of) Examine RESPIRATORY FAILURE Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated avents rasulting in death) Last Dua to (or as a consequence ot): pue 68X60 edical Dua to (or as e consequence of) **Physician/M** Box Pert II. Other slanificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 2 XXXVes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of ceusa of death? The law certificate hes t 1 Yas XXXINO 1 ☐ Yes 2 ☐ No or Attending Physician: director Be 25. Was cesa raferrad to medicel exeminer? 26. Placa of Daath (Check only one) Othar: 4 ☐ Nursing Homa XX Rasidance 6 ☐ Othar (Specify) Certification: To 1 ☐ Yas XX No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Invastigation XXNatural 1 Yas 2 No 2 Accidant Director: / 6 Could not be datarmined 3 Suicide 28t. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicide 24 hours efter Funeral Dire letely filled in b 29a. Certifiar 🐰 Certifying Physician: To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. edicai (Check only one) 2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the ceusa(s) and manner stated. within 2 To the I 29b. Signeture and titla of certific 29c. License number 29d. Date signed (Month, Day, Year) 902 30. Nama and addrass of person who sempleted cause of death (Item 23e) (Type, Print) 3ld 8 Rm 5101 NAVAL LASP. Tal 10+1 ONCOLOM Oroc WAVY 31. Data filad (Month, Dey, Yaar) 32. Redistrar's Signatura 1998 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Minnie 1755 30, 1998 August · /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALLIMORE, CITY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Hopkins Hospital Sex 7. Age (In yrs. last birthday) JUHNS Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 1□ M 2□ F Vrs 215-24-1112 Director APR. 17,1921 VIRGINIA Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1416 DARLEY AVENUE 21213 U.S.A. death Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after ment of Hauth and Mental Hygiene.
Int If Itam 27 Is marked other than "natural", or ite my or other traumate event, the Medical Experient. 1 Never Married 2 Married 1 Yes 2 No altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: NEGRO À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5TH DOMESTIC PRIVATE HOMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be WILLIAM H. YANCEY ANNIE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLADYS ABBOTT NIECE 1416 DARLEY AVE. BALTIMORE, MD. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) LOUDON PARK CEMETERY SEPT. 5, 1998 BALTO, MD. 21. Service of Funeral Service Local 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock, or heart failure. List only one cause on each limit. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ardiomyopaT disease or condition resulting in death) Une year Examine Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): edical Due to (or as a consequence of): Physician/M 23b. Did tobacco use contributa to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. ed by the Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause 24a. Was an autopsy performed? Completed 1 Yes 2 100 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funaral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural aftar death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner as stated. complately 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier m.D. RES-000 August Thinketh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Huspital, 650 North Wolfe Street, Bultimore, maryland Johns Mupkins Krain Kinchen, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 0 3 1998 oaks Dagerma Registra



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29d. Date signed (Month, Day, Year) 29c. License number 250757

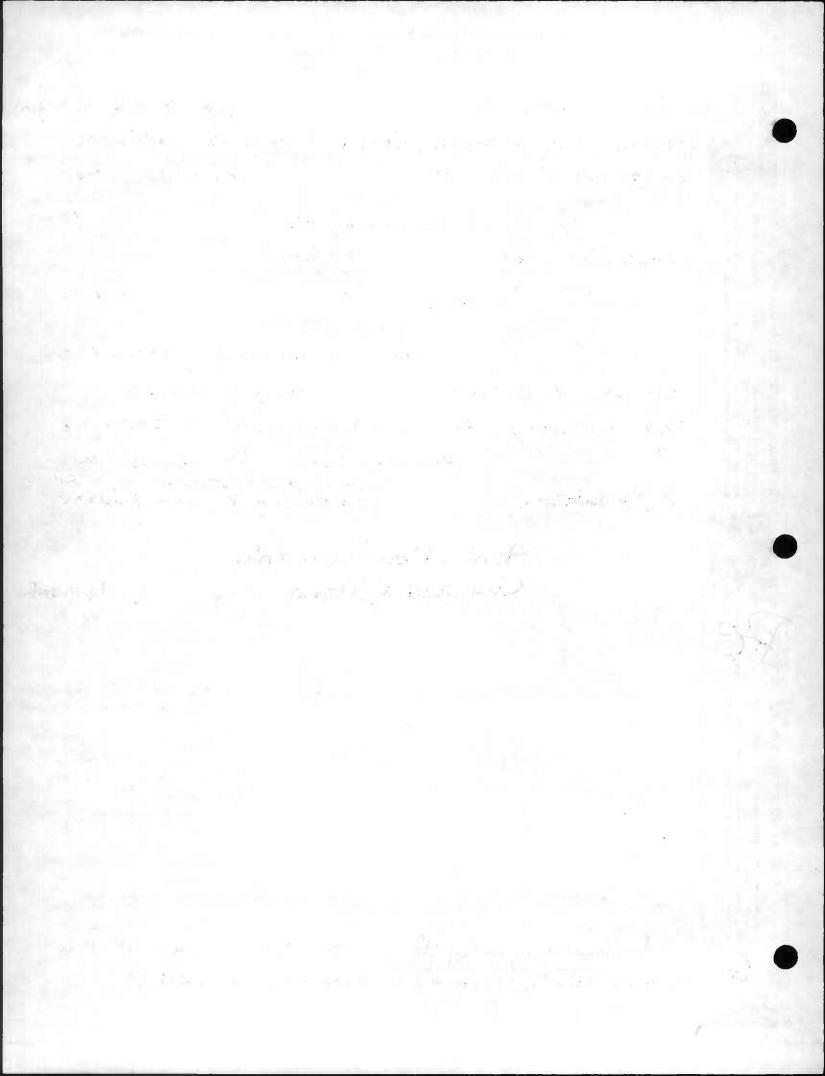
1998

30. Name and address of person who completed cause of deeth (flom 23e) (Type, Print)

9105 Nonklin Sq drice # 312. Baltinase. MD 21237.

State Registrar

31. Deta filed (Month, Day, Year) SEP 0 3 1998 32. Ragistrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** 31, 1998 4c. County of Deeth CHEELSMAN D AUGUST 12:50 PM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9015 PERP 5. Social Security Number PERPING PARK 120 BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□F Months Days Hours Usual Residence of Decedent Director JAN. 13, 921 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE PARKVILLE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ò Items 23a 13. Was Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) U.S.A -14. Race - American Indian, Funeral PARIL RD death 9015 PERPING 12. Wes Decedent Ever in U.S. Armed Forces?

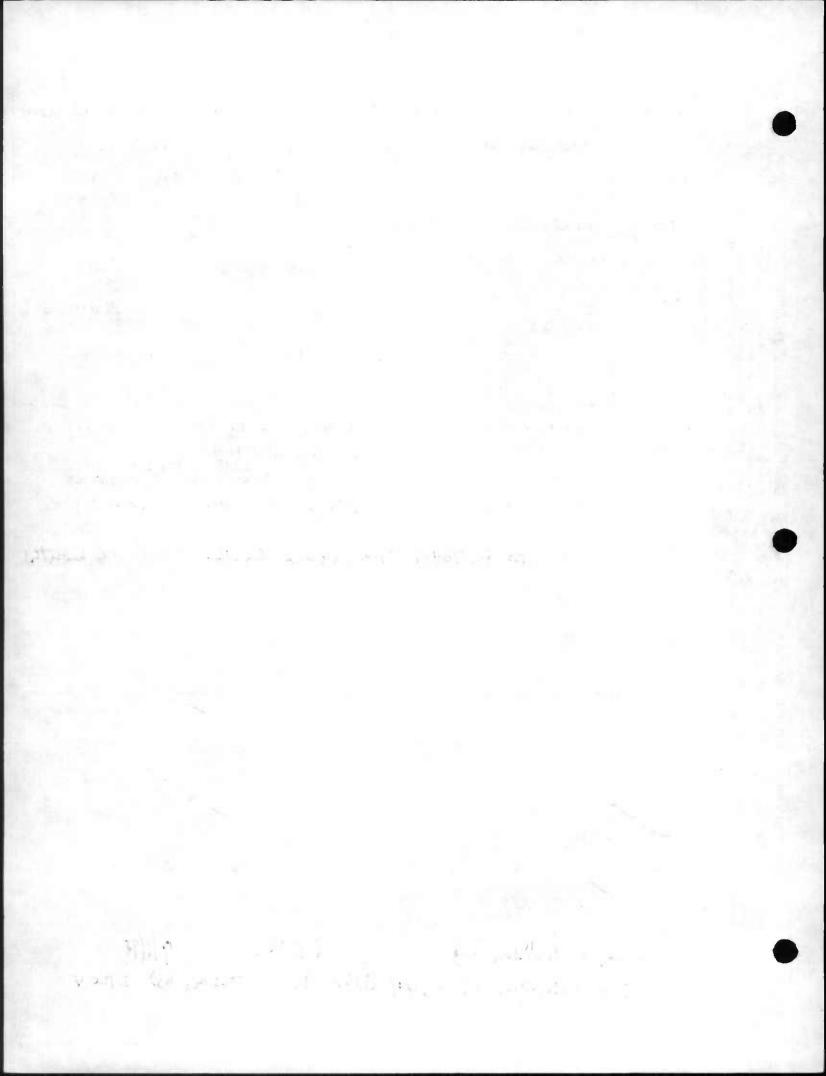
1 Yes, 2 2 No If Yes, Give Year or Dates: 11. Meritel Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after on end of Health and Mertal Hyglena.

Int: If item 27 is marked other than "natural", or Neury or other traumate avent, the Medical Energy any or other traumate avent, the Medical Energy. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Baitimore, Maryland 21215-0020 by 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 124RS AT HOME HOME MAKETE 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be FUGENE E. DAVIS EVA. M. SYDNOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Ratallonship (Type, Print) 9DIS PEDRING PARK P.D. BALTIMORE, N.D. 21234 be of Disposition (Name of Date 20c. Location - City or Town, Stete FRANCES M. GEIER, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
PINE GROVE UNITED METHODIST SEPT. 4.
CHUPCH CEMETERY 1998 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □Removel from Stete permit. Page Department of Important: If any Injury or page. 4 ☐ Donetion 5 ☐ Other (Specify) 1998 RAYVILLE, 21. Significant Funeral Service Licensee 22. Name end Address of Fecility EVANS CHAPEL OF MEMORIES 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

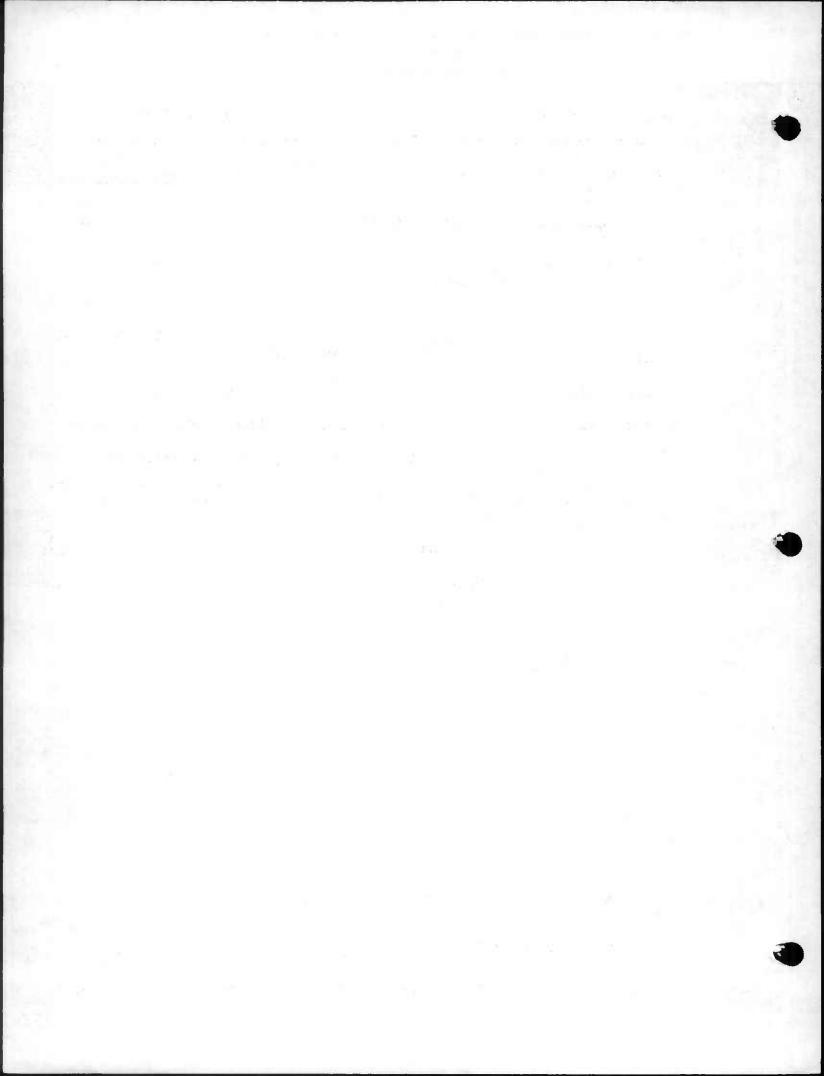
Approximate Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final Metastatic CARCINOMA LUNG disease or condition resulting in death) Examine Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as e consequence ot): edical Due to (or es e consequence of): Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 Tes 2 No 3 Probably 4 Unknown signed b þ page 2 should b 24b. Were autopsy tindings evailable prior to completion of cause of daeth? 24a. Wes en autopsy performed? Completed 1 Yes 2 No 1 □ Yes 2 □ No or Attending Physician: director. 8 25. Wes casa referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturel 5 Pending investigation n 24 hours after death.

Ne Funeral Director: A pletely tilled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifier To the Fune completely t (Check only one) within 2 To the 29b. Signeture and titla of certifier 29d. Date signed (Month, Dey, Year) 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Tower, has January H B 31. Dete filed (Month, Day, Year) m) 32. Registrar's Signature State SEP 0 3 1998 Registrar



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O. sales	Certification:	3 ☐ Suicida 6 ☐ Could not 4 ☐ Homicida datarmine	20a. Flac	a of Injury - At I ding, atc. (Spec		aat, factory	y, offica			(Straat and Num own, Stata)	ber or Rural F	Routa Numb	ar,
diami	edical	29a. Cartifiar (Check only one) Certifying P	minar: On the I	a best of my knobasis of axaminonar stated.	owledga, daath ation end/or Inv	occurrad astigation	at tha ti	ma, data and pla opinion, daath oc	ce, and dua to the currad at the time	causa(s) and m , data and place	annar as stat , and dua to th	ed. na causa(s)	
	= -	29b. Signatura end title of certifier				290	c. Licens	se number		29d. Date sign	ed (Month, De	y, Yaar)	
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							4080	164		SONT	< 1003	5	
		30. Name end addrass of parson who	complated cau	isa of daath (Ita	m 23a) (Type, I		100			Sept.	3, 133		



The law requires that the death Division of Vital Records, P.O. the signed by the been si certificate hes t director, this funeral After !

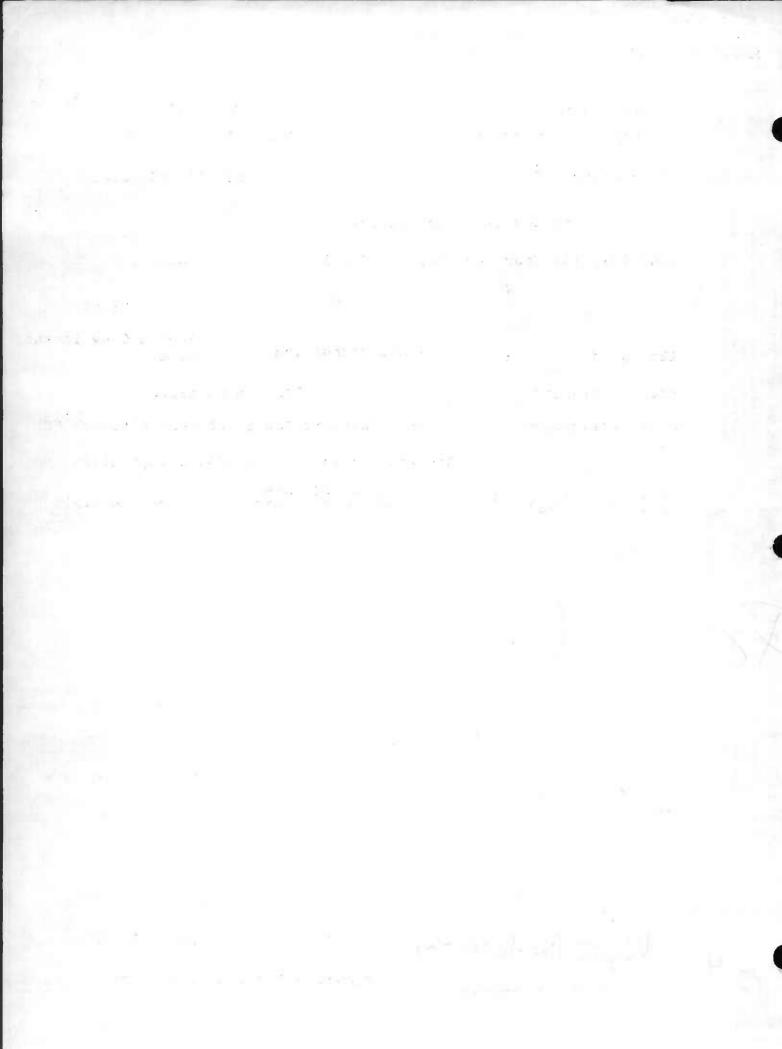
State Registrar

98-5100-005 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RONALD CURLINGTON ITEMS: #23 PART I, 27, 28A-F PER MEO G763 9-11-98 WR. Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** 0539 AM RONALD CURINGTON

4e Fecility Nama (If not institution, give street end number) AUGUST 30, 1998 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 3507 FOXCLIFF COURT APARTMENT 2 RANDALLSTOWN BALTIMORE if Under 1 Year 7. Aga (In yrs. last birthday) 5. Social Sacurity Number Birthplace (State or Foreign Country) **Funeral** 1 XM 2□ F Months Deys Hours Yrs. **Director** 579-74-6352 Usual Rasidance of Dacedant 42 55 D.C 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☒ No ector Balto County MD Randal1stown 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 늄 Court Apt T-2

12. Wes Decedent Evar in U,S.
Armed Forcas? Funeral 3507 Foxcliff 21133 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Bleck, White, atc. 1 □Xas 2 □ No If Yas, Giva 1 Never Married 2 X Married 1 Yas 2 No Specify: by 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas: Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona duning most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Jewish Convalscent Collega (1-4or 5+) Floor Technician 12th grade Home 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Neme (First, Middle, Last) Be Frank Curington Ella Mae Copeland 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rural Routa Number, City or Town, Stata, Zip Code) permit Pages 1 and 2 sh Department of Health end Important: if item 27 is m any injury or other traum other T-2, Baltimore Nora Curington-wife 3507 Foxcliff Court Apt 20b. Place of Disposition (Name of cematary, crametory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data \*Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 9/4/98 Owings Mills, Md Garrison Forest Vet 22. Nama and Addrass of Facility March F/H West 4300 Wabash Ave, Baltimore, Md A 21215 4300 Wabash Ave, Baltimo Part Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death /Medical immediata Causa (Final diseasa or condition resulting in death) a. NARCOTIC INTOXICATION **Examiner** Dua to (or es e consequance of): Examine Sequantially list conditions, if any, leading to immadiate ceusa. Entar Undarlying Causa (Disease or Injury that initiated avants resulting in deeth) Last Due to (or es e consequence of): Physiclan/Medical Dua to (or as e consaguance of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Wes an eutopsy Completed 1 Yas 2□ No 10 Yes 2 □ No or Attending Physician: 25. Was cesa rafarred to medical examinar? Be 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Masidance 6 Othar (Specify) Hospital: 2 XXYas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) FOUND 8-30-98 28b. Tima of 28d. Describe how injury occurred 27. Mannar of Death Certification: 28c. Injury et Work? FOUND 4:45M 1 Naturel 5 Panding UNKNOWN 1 Tes 2 No invastigetion within 24 hours efter death To the Funeral Director: / completely filled in by the 2 Accidant 6 Could not be 3 ☐ Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 3507 FOX CLIFF COURT, RANDALLSTOWN, MARYLAND 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 Homicida RESIDENCE 1 Certifying Physician: To tha bast of my knowladga, deeth occurred et the time, date and plece, and due to tha cause(s) end menner es stated.

\*\*Medical Examiner: On tha bests of axaminetion and/or investigation, in my opinion, deeth occurred at the tima, date end place, and due to the cause(s) and mannar statad. 29a. Certifier edical (Check only one) 29b. Signatura and titla of certifias 29c. License number 29d. Data signed (Month, Day, Year) O.C.M.E. AUGUST 30, 1998 Mynie 30. Name and address of person who complated causa of daath (Itam 23e) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 113 Mysnus 1001487 31. Deta filad (Month, Day, Year) 32. Registrer's Signature SEP 0 3 1998



Attending ö within 24 hours a To the Funeral C completely filled

State Registrar

KI Y CHUNG, 31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

SINAI HOSPITAL 32. Registrer's Signeture

MD

BALTO MD

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29c. License number P09292

29d. Date signed (Month, Dey, Yeer)

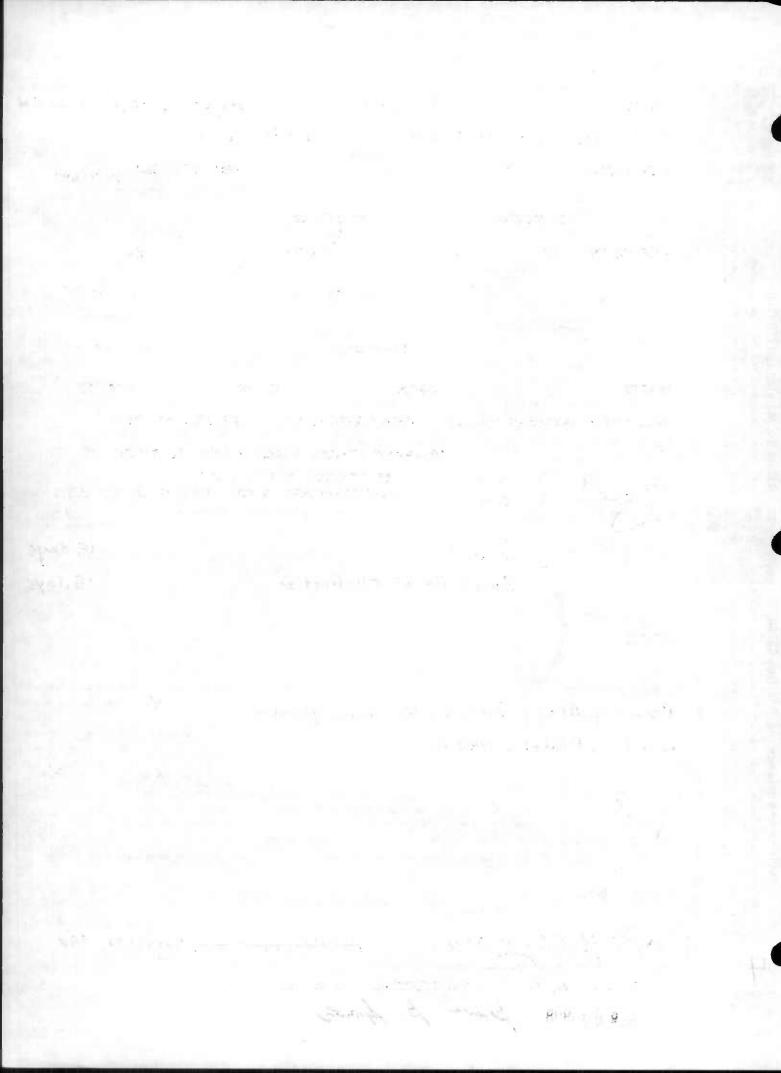
August 31, 1998

29a, Certifie

(Check only one)

29b. Signature and little of certified

edicai



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** ugust /Medical 4b. City, Town, or Location of Deeth 4c. County of Death Name (If not institution, give street and number) Examiner Baltimore
If Under 24 Hrs. 8. Dete of Bir 8. Dete of Birth Month, Day. yrs. last birthday) 5. Social Security Number If Under 1 Yeer lace (State or Foreign **Funeral** Deys 1 M 2□F Months Hours Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or fems 23s or 28s-f show traumstic event, the Medical Examinar must be notified at 1 Yes 2 No Director larvland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 861 death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygians. Important: If Itam 27 is marked other than "natural", or itam any Injury or other traumatic event. Bleck, White, etc. 17) Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2XNo Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 8 19b. Meiling Address (Street and Number or Rural Route Number, City or Town daughter 20b. Place of Disposition (Neme of cemetery, crematory or other) 20a. Method of Disposition /Dete/ 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 DOther (Specify) 22. Name end Address of Facility
To Seph L. Ky 21. Signature of Funeral Service Ligens Home Russ eral Md. 21216 22 Ave. se, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 10 Examiner Examiner Sequentially list conditions, if erry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, arrh 10 Physician/Medical Due to (or es a cons signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24e. Was en eutopsy performed? 24b. Were autopsy findings aveilable prior to Completed completion of cause of death? 2 1 No 1 Yes 20 No this certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this cardifor completely filled in by the funeral director; it Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1□ Yes 21 No 1 (Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 1 Naturat 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Hospital, Baltimore Wang St m D anes RULLA

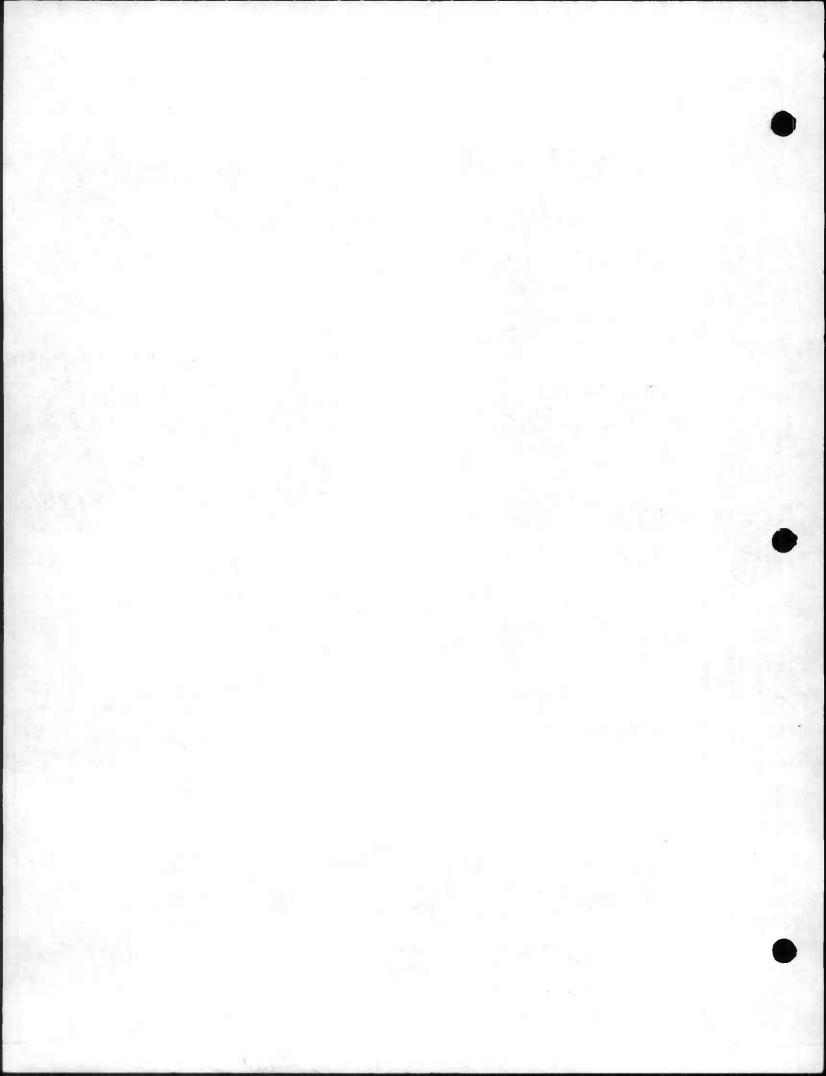
**DHMH 16 Rev 6/95** 

Registrar

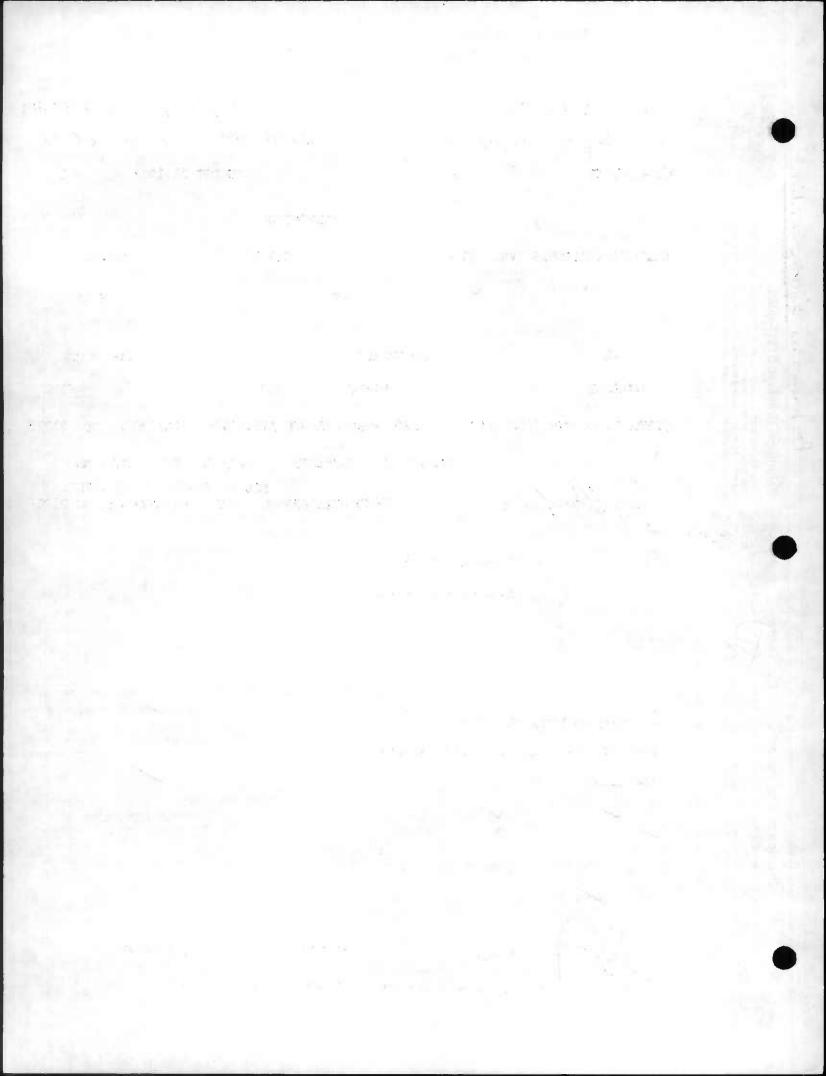
31. Date filed (Month, Day, Year)

0 3 1998

32. Régistrar's Signature



an 1					Cer	tificate of	Death		eg. No.		the City thelece (Stata or Foreign numbry) MD  10d. Inside City Limits Ye'es 2 \( \) No  note Indien, e, etc.  HITE Andustry  HOME  KATZ  Zip Code)  MD 21215  Town, Stata  1, MD  , INC.  Approximate Interval Between Onset and Death  Onset and Death  Wara autopsy findings evellabelic prior to competent of cause of daeth?  1 \( \) Yes 2 \( \) No	
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al	Sylvia		ardin				b. City, Town, or Lo	August			1:43 AM	AM  y r Foreign  y Limits 2 No  Z  215  208 9 ween Death  Unknown  indings o ause No
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3	213-09-72		1 M 2 M F		Yrs.	Months Deys	Hours Min.	8. Date of Birth (Month, Day	Yeer)	Counti		
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Director	MD		N/A			BAI	TIMORE				Yes 2□No	
1	10e. Street end Numb	per				10f. Zip Code		1	0g. Citizen of Wi	het Counti	ry?	
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1	11. Maritel Status		12. Was Dec	edent Ever in U.S	S. 13. V	Wes Decedent of H	lispanic Origin? (Sp en, Mexican, Puerto	ecify Yas or No- Rican, etc.)				
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3		5. Decedent's			16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind of Bus	iness/Indu	ustry	
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3 1	17. Father's Neme (Fi		est)				18. Mother's Nem	e (First, Middle, i	<i>maid</i> an <i>Sumem</i> e	)		
2	EMANU					DAHNE	ROSE		-			
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-	MEYER M.  20e. Method of Dispos		N (HUSBA			PARK HE]	GHTS AVE	. #704 Dete				
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cal Examiner	Immediate Ceuse (Firdisease or condition resulting in death)  Sequentielly list cond if any, taeding to immeause. Enter Underly Ceuse (Disease or in) that initiated events	ditions, nediate ying jury				juence of):			*			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month REGINA COLLINI LEONA 11:55 PM 1998 4b. City, Town, or Location of Death 3 /Medical 4e. Fecility Neme (If not Institution, giva straat and number) 4c. County of Deeth Examiner GOOD SAMARITAIN HOSPITAL BALTIHORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) Birthpleca (State or Foreign Country) **Funeral** 1 M 2 F 214 14 P674 Yrs. Maryland Director 11-6-1922 Usuel Rasidence of Dacedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland ant of Health and Mental Hygiene. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show BALTIHORE 1 PYes 2 No Director MARYLAN N/A 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? 3628 ELMORA AVE 21213 US A Funerai 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armad Forces? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Stetus 1 Yes 2 No
If Yas, Giva
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE þ 3 ₩idowed 4 Divorced Completed 7 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grada completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker 8th Grade Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Melden Sumeme) Be Peter Barthowiak 2 Valeria Hoppa 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) of Health & I Itam 27 i Anthony Collini (Son) 13 Peabody Court, Bel Air, Maryland 21014 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. = 5 4 ☐ Donetion 5 ☐ Other (Specify) 9/4/98 Baltimore. Maryland Gardens of Faith 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Schimunek Funeral Home Inc.
3331 Brehms Lane, Baltimore, Maryland 21213

or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approximate Mark 23a. Pert1. Enter the disaase shock, or heart failura. Approximate Intervel Between **Physician** of Livin & Some /Medical Immediate Cause (Finel Approx. diseese or condition resulting in daath) Examiner burlai-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Entar Undarlying Causa (Disaase or Injury that initieted events resulting In daath) Last Due to (or es e consaquance of): Box 68760. edical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown À 24b. Were eutopsy findings eveitable prior to complation of causa of daeth? 24a. Was an eutopsy performed? Completed LIVEN 610ps page 2 s 20 No certificate Hospital or Attending Physician: 25. Wes cese rafarred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Residance 6 Othar (Spacify) 2 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatiant After this 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Panding investigation 1 DNaturel eftar death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Streat end Number or Rurel Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner as steted.

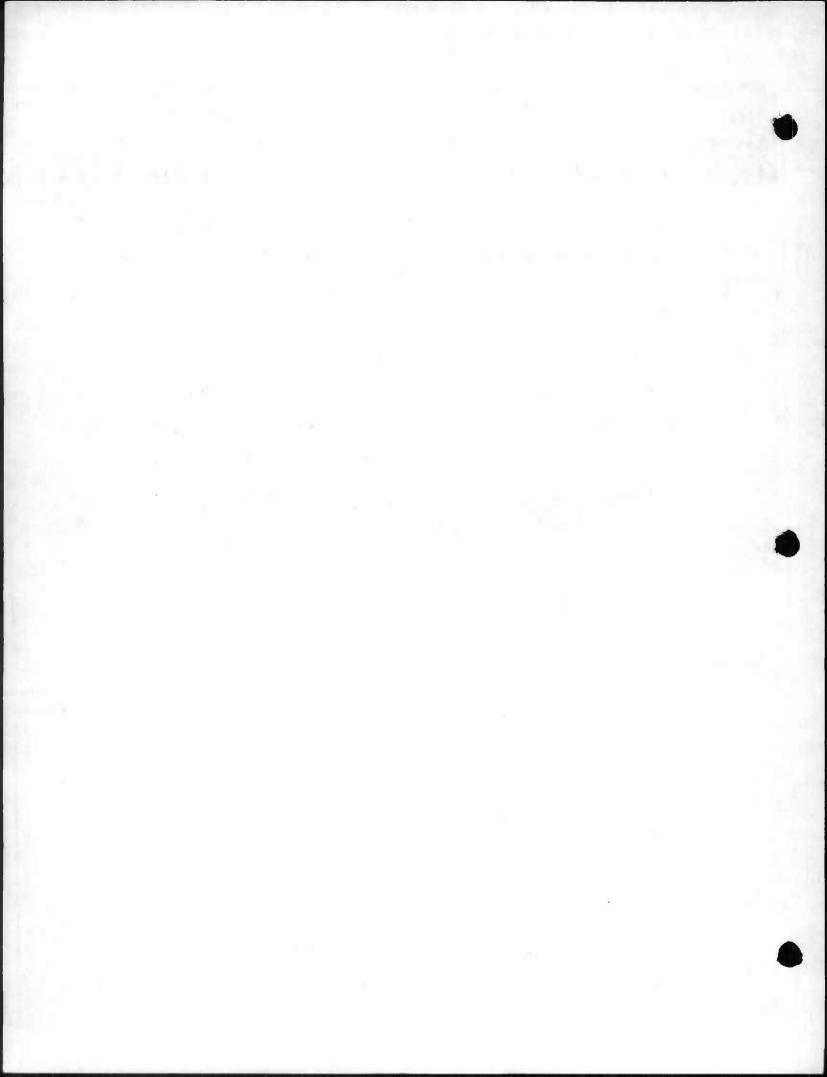
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier To the Hospi within 24 hou To the Funer completaly fil Medical 29b. Signeture end title of certifier 29c. Licensa number 29d. Date signed (Month, Dey, Yeer) 30. Name end eddrass of person who completed ceuse of death (Item 23e) (Type, Print) TAN, MD. FELIX ISALTIMORI, IND. 4000 ERDMAN AVE,

32 Registrer's Signetura

merra

Registrar

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** August 26, 1998
cation of Deeth 4c. County of Deeth CECILIA HELEN DOXZEN LANE 8:50 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) **Examiner** Stoneleigh
If Under 1 Year | If Under 24 Hrs. | 8.
Months | Deys | Hours | Min. Armacost Nursing Home Baltimore County 7. Age (In yrs. lest birthday) 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2♥F Deys Yrs. 89 Director 214-24-3694 Usuet Residence of Decedent Maryland Jan 27, 1909 the Maryland 10e, Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Baltimore County Lutherville 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or item in Injury or other traumatic event, the Modical Examples roughly in once. 1508 Greenspring Drive 21093 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Å Year or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) 12th Registered Nurse Medical 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John William Doxzen Martha Ann Bigley 19e. Informent's Neme/Reletionship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marion E. Lane (Dghtr-in-Law) 1508 Greenspring Drive, Lutherville, MD 21093 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Buniel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Saters Baptist Ch Cem. 8/31/98 Lutherville, Maryland 21. Signature of Funeral Service Libera Marley Allson Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.

212.12 Approximete Intervel Between Onset end Death **Physician** 2 days /Medical Immediate Ceuse (Final disease or condition resulting in death) myorandial Infanction Examiner Due to (or es a consequenca of): 5 Yvot Examine Chronic obstructive pulmonary disease Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury cian Dementia of replemens type Box/68760 edical thet initiated events resulting in death) Lest Due to (or es e consequenca of): 2 Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yee 2 No 3 Probably 4 Tunknown p 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 24e. Wes an eutopsy Completed 1 Yes 2FTNo 1 ☐ Yes 2 ☑ No 25. Wes case referred to medicat exeminer? 26. Piece of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1□ Yes 2⊠No 2 2 28d. Describe how injury occurred 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. tnjury et Work? Certification: After Attending 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident Director 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide ò 24 hours e 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Dey, Year) 29b. Signature end title of cartifier 29c. License number Mian-Door Kidump, mo 031865 8/28/98

State Registrar 31. Dete filed (Month, Day, Year)

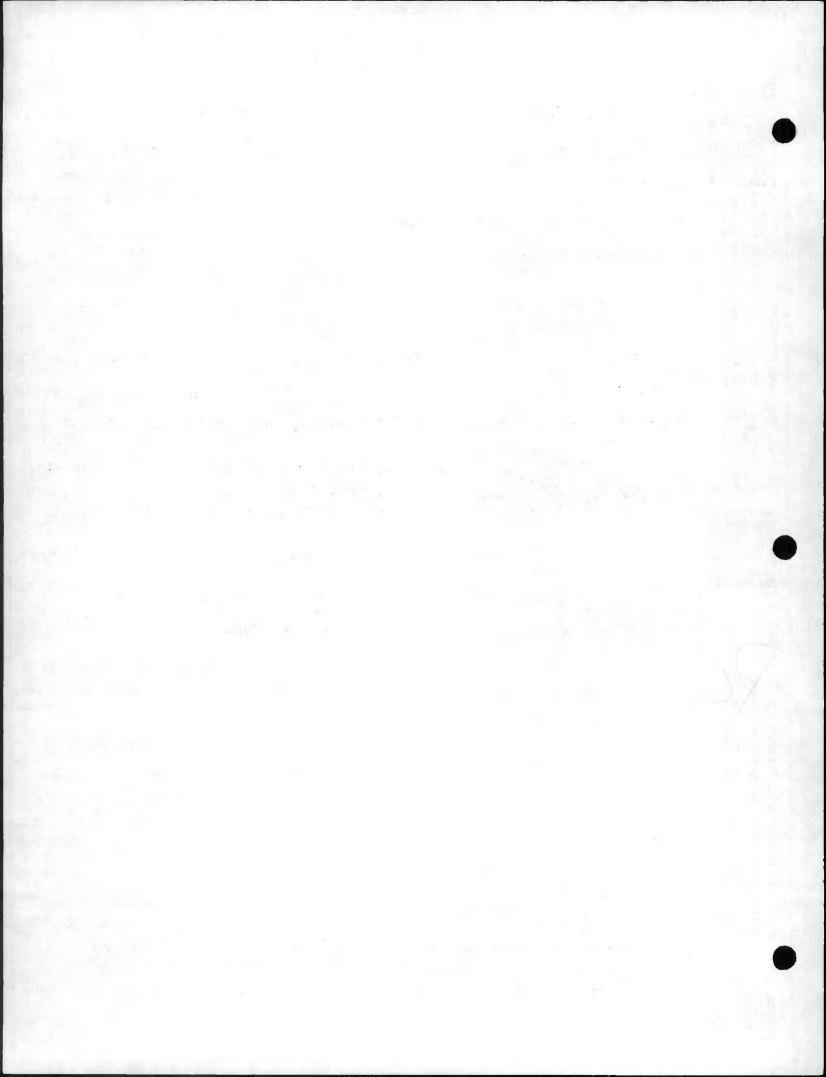
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

SEP 0 3 1998

Mien D. Kioune, M.D., 416 E. Joppa Road, Towson, MD 21286

Sparker

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26894 Certificate of Death Reg. No. 2. Date of Death 1. Decadent's Nama (First, Middla, Last) 3. Tima of Death 08731/989 Ida Deinlein 1:45 AM 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Stella Maris Towson Baltimore 5. Social Sacurity Number If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/25/1897 Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months Days Hours 1□ M 2□ F 100 Yrs. Maryland 216-05-9169 Usual Rasidance of Dacedant 10b. Counts 10c. City, Town or Location 10d. Insida City Limits Baltimore Baltimore 1 ☐ Yas 24 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2300 Dulaney Vally Road 21093 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married Specify: White 1 ☐ Yas 2 ☐ Mo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Housewife Home 18. Mothar's Nama (First, Middle, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) John Tauber Mary Biebel

20b. Placa of Disposition (Nama of cematary, cramatory or other place)

Holy Redeemer Cemetery

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 760 W. Shore Trail Sparta New Jersey 07871

9/3/98

22. Nama and Addrass of Facility Dippel Funeral Home Inc.

7110 Belair Road Baltimore, Maryland 21206
Approximata Intarval Batween Onsat and Death

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Modical Examinal must be not find an once. Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10a. Stata

MD

19a. Informant's Name/Ralationship (Type, Print)
Joan Stang

4 Donation 5 Other (Specify)

21. Signatura of Funaral Sarvice Licensas

1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata

20a. Method of Disposition

Director

Funeral

þ

Completed

**Funeral** 

Director

**Physician** /Medical Examiner

Examiner

Pull physi by the e 2 been sig certificate has b director, page 2 s director. this After this funeral 24 hours after death.

Funeral Director: Af neral Director: A

Division of Vital Records, P.O. Box 68760

The law requires that the death certificete by

or Attending Physician:

Immediata Causa (Final disease or condition resulting in death) MyoCARDIAL INFARATION ARTEMO SCLENTIC CARNO VASCULAR Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Physician/Medical Dua to (or as a consaquance of): 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown + IRRILATON þ 24a. Was an autopsy performed? Completed 1 Yas € No 25. Was casa rafarrad to medicel axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: Othar: 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas Certification: To 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding Invastigation Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicida

To the F within 2

Registrar

edical

29b. Signatura and titla of souther

29c. Licansa number

D25686

12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Data signad (Month, Day, Year)

20c. Location - City or Town, Stata

Baltimore, Maryland

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

24b. Wara autopsy findings available prior to completion of cause of death?

1 ☐ Yas 2 ☐ No

EBRAHIM IPAKCH, MD

OSLEA DAING BATIAGE US ZIRES

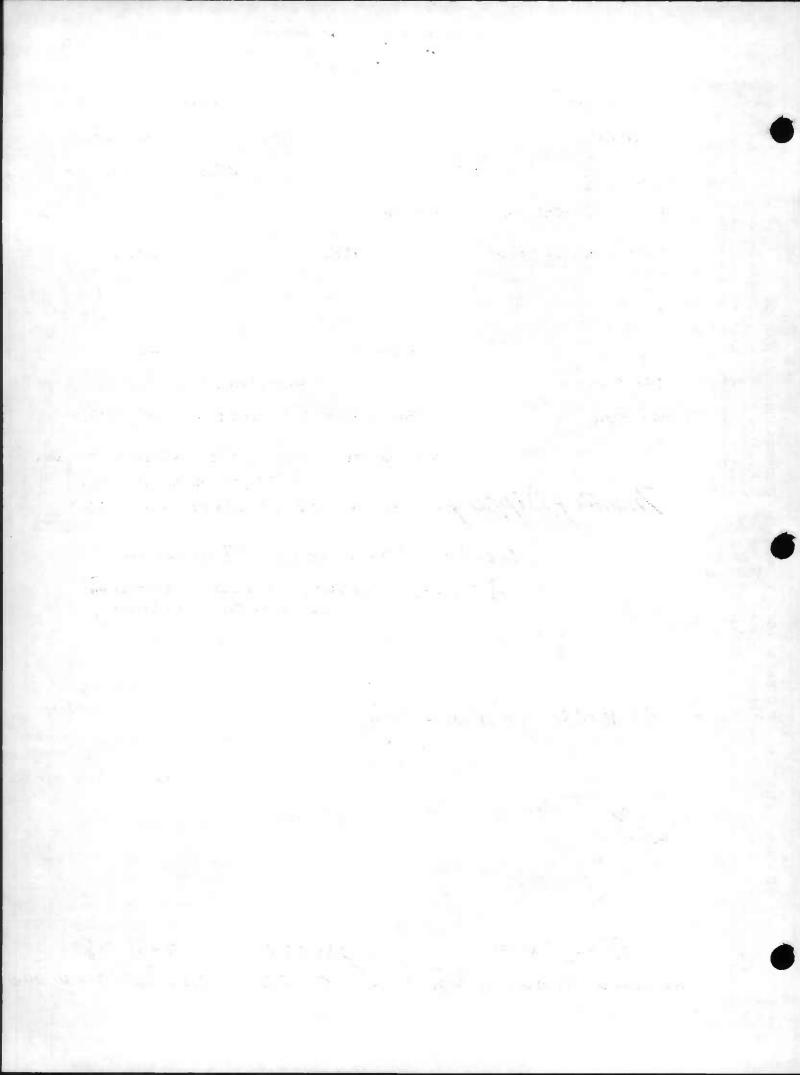
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31. Data filed (Month, Day, Year)

29a. Cartifian

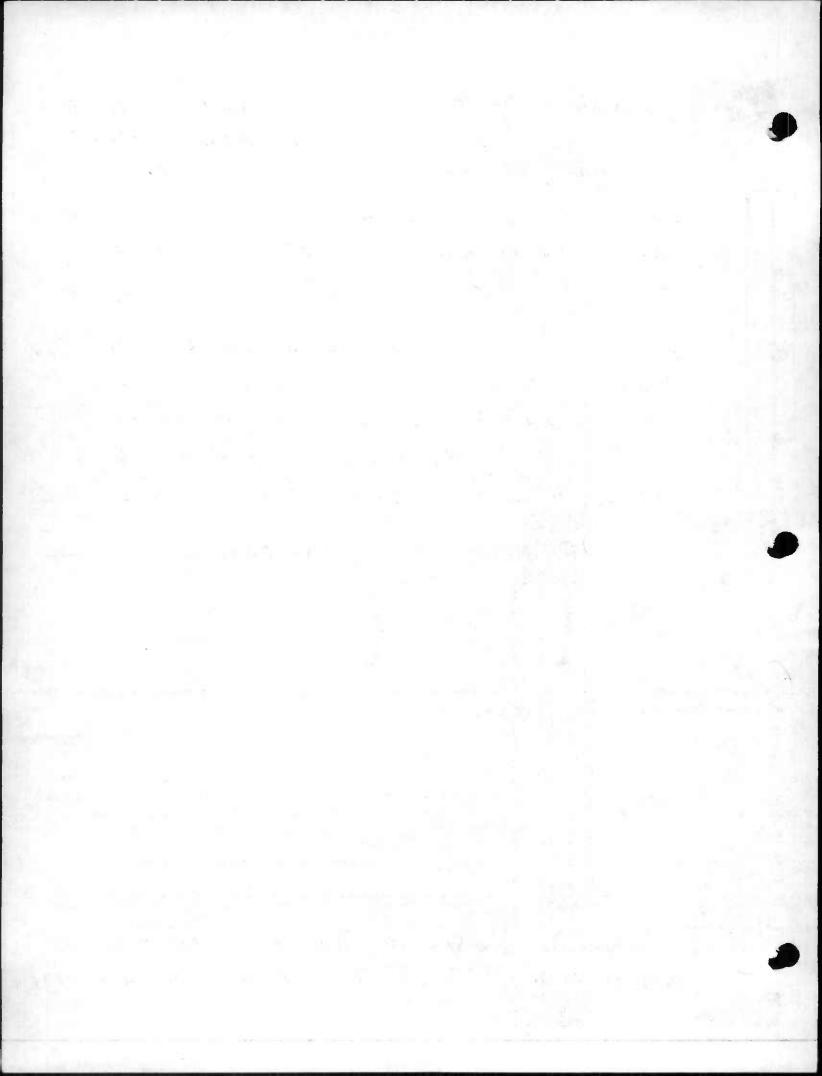
(Check only one)

32. Registrar's Signatura

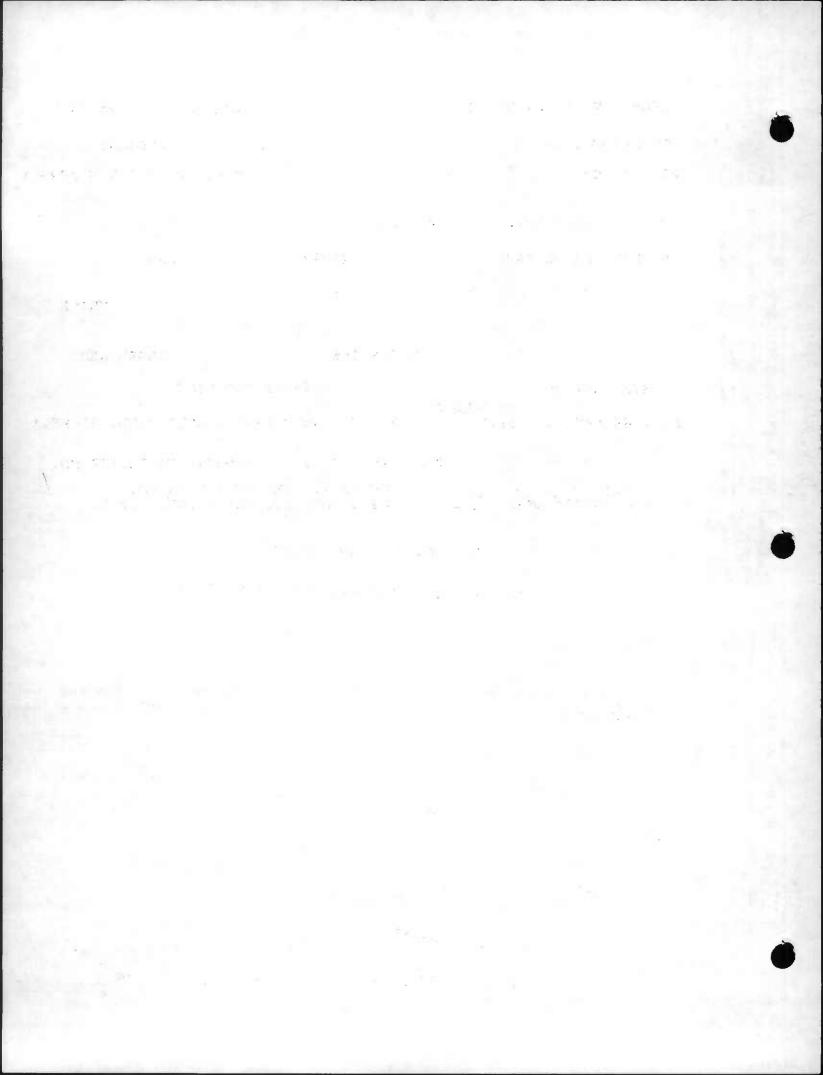


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daeth AUGUST **Physician** A. DALTON LILLIAN 1040 A /Medical 4a. Facility Name (If not institution, give streat and number) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3 4 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hos Church Home 7. Age (In ys. last birthday) 5. Social Security Number 6. Sex Birthplaca (State or Foreign Country) **Funeral** 1□ M 20 F 233-54-7216 64 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23e or 28e-f show ner must be notified at Battimore 1 Tas 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Kitland U.S.A. 1609 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 14. Race - American Indian, Bleck, White, etc. Baltimore, Maryland 21215-0626 A 1 Never Marriad 2 ☐ Married 1□ Yas 21 No 'natural', or Black Spacify: Completed by filed within 72 hours 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Batto. City Eiementary/Secondery (0-12) College (1-4or 5+) Investigator Child Health 12th 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surname) Be hand-Mental a Pages 1 and 2 should be Theodore Datton Hairston OL 19e. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Numbar, City or Town, Stete, Zip Code) Rutland Are, Battimore, MO Konald m. Important: If item 27 any Injury or other to 20b. Place of Disposition (Name of cematery, crematory or other p 20a. Method of Disposition 20c. Locetion - City or Town, State 1 Buriai 2 □ Cramation 3 □ Ramoval from State Randallstonn, MD mem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funaral Sarvice Licensae 1101 E. North Ave F. H EAST March 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediate Ceuse (Final OVARIAN CANCER years disaase or condition resulting in death) **Examiner** Physician/Medical Examiner the bunal-transi Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events rasulting in death) Last Due to (or as a consequence of): 68760, Dua to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. DISEASE 1 Yes 2 No 3 Probably 4 Unknown RENAL by 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy this certificate 1 ☐ Yes 2 1 No 2 No 1 Yas Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Lo 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Netural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yaar) 29c. License number med - Specialist 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) HAVARRO, MD. Baltimore, Maryland 21231 100N Broadway WENEUSA 31. Dete filed (Month, Day, Year) SEP 0 32. Registrar's Signatura State Registrar

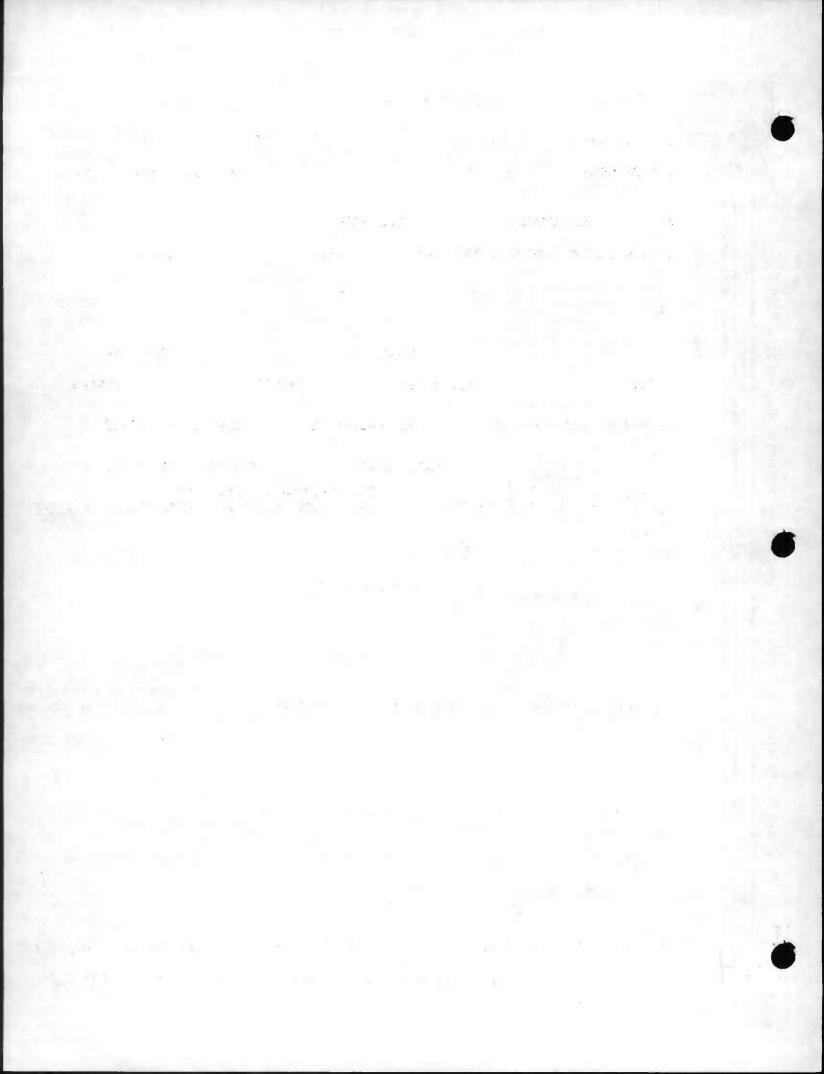


			Certifica	te of L	Death		Reg. No.		
1. Decedent's Name (First, Middle, Las	st)		V. A.					Yeer	3. Time of Death
APHRODITE V.	diBRAND1					SEPTEM	BER 01	1998	01:33 AM
4e Fecility Neme (If not institution, give	e street end number)			4	b. City, Town, o	r Location of Dea	th 4c. Cour	nty of Deeth	
				er 1 Year	TOWSON If Under 24 Hr	S. 8 Date of B			place (State or Foreign
1						. (Month, D	lay, Year)		plece (Stete or Foreign ntry)
Usual Residence of Decedent		75				FED.	10,19,	SD NE	W JEKSEI
10a, Stete 10b. County		10c. City, To	wn or Location					1	10d. tnside City Limits
MD BALTI	MORE	TIMO							1 ☐ Yes 2 No
10e. Street end Number			10f. Z	ip Code			10g. Citizen o	of Whet Cou	ntry?
		Ever in II C	12 Was Dee			Cassily Vac or N	USA	ace - Ameri	cen Indien
	Armed Forces?		If Yes, sp	ecify Cube	n, Mexicen, Pue	rto Rican, etc.)	B		
3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140	1 ☐ Yes	254 No	Specify:		200	W. W.	HITE
		160	e. Decedent's Us	uel Occup	etion		16b. Kind of		
		5+)	life. DO NOT	use retired	ouring most of w	orking			
	5+		HOUSEWI	FE					ER
								eme)	
	GIBRAND	_			KMS LF	T	T		
1 ₺ Burial 2 □ Cremation 3 □		cemet	ery, crematory or	other plea					
		MT.				19/05/9	8 FREI	DERIC	K,MD.
in a	, , _					INS & S	ONS CO	).	
23a Part Enter the disease or com	plications that cause	d the death Dr	4905	YOF	RK RD.	BALTO.	,MD. 2	21212	Approximete
shock, or heart failure. List only	one cause on each li	ne.				,			tnterval Between Onset and Death
tmmediate Cause (Finel	6	ardo	ac /	Zur	ent				
resulting in death)	θ.			,		0 /	0 /		
	Coron	ary A	rtery	Dis	ease 1	Hortec	Sten	0515	
Sequentially list conditions,	0.								
Cause (Disease or Injury	C								
that Initiated events resulting in deeth) Last		Due to (or as e	consequenca of	):				1	
	d								
Data Other Institutes and Males			t- 10		- I- D I	OSE DI	d Anhanan was		to the sause of death
0 1		out not resulting	in the underlying	cause giv	en in Pert I.				bably 4 Unknow
Vasete	1					_	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0 0 111	,
						24a. We	s en eutopsy formed?	91	Vere eutopsy findings vailable prior to
								C	ompletion of ceuse f death?
						10	Yes 20 No	1	☐ Yes 2☐ No
25. Was cese referred to medical			/		26. Place of D	eath (Check only	one)		
1 ☐ Yes 2 ☑ No	1 Li Inpatie		Outpetient 3 1	JOA	4 LI Nuising				ify)
1 Neturel 5 ☐ Pending		y Year) 28b.	Injury			28d. Describe	e how injury occ	curred	
Z D Addidont					Yes 2∐No	OOS I meetion	(Character and Mile	m hos os Pu	ral Paula Alimbar
4 ☐ Homicide determined	28e. Place of In building, et	iury - At home, c. (Specify)	farm, street, fact	ory, office		City or T	own, Stete)	m <i>ber</i> or Hui	rai Houre Number,
29a Cartifier 10 Cartifying Ph	weigles: To the host	of my knowledge	o dooth coourse	d at the tin	ne data and nie	ne and due to th	o couse(s) and	menner es	stated
(Check only one)	niner: On the basis o	f examination e	nd/or investigation	on, in my o	pinion, death oc	curred et the time	e, dete and pled	e, end due	to the ceuse(s)
29b. Signeture end title of certifier			2	9c. Licens			29d. Date pig	ned (Month	Day, Year)
	10	M	>	122	4732	)	0./	1	
30 Jan	rence	1-12		0 2	1/2		7///	54	
30. Name and address of person who	completed ceuse of	death (Item 23a	) (Type, Print)			rouf	7/1/	98	usun, Me
	APHRODITE V.  4e Fecility Neme (If not institution, given GREATER BALTIMOF 5. Social Security Number 2. 19-14-90.49  Usual Residence of Decedent 10a. Stete 10b. County MD BALTI 10e. Street end Number 46.2 FIVE FARMS 11. Marital Stetus 1 Never Married 25 Married 3 Widowed 4 Divorced 15. Decedent's Expecity only highest green Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, Last, KOSTA VAEILOU 19a. Informant's Neme/Reletionship (REV. HERMAN A. 20a. Method of Disposition 1 Burial 2 Cremation 3 Double of County (Specification of Co	4e Fecility Neme (If not institution, give street and number)  GREATER BALTIMORE MEDICAL  5. Social Security Number  6. Sex  219-14-9049  Usual Residence of Decedent  10a. Stete  10b. County  MD  BALTIMORE  10e. Street end Number  462 FIVE FARMS LANE  11. Marital Stetus  1 Never Married 3 Widowed 4 Divorced  15. Decedent's Education  (Specity only highest grade completed)  Elementary/Secondary (0-12)  College (1-40rt)  5+  17. Fether's Name (First, Middle, Last)  KOSTA VAEILOU  19a. Informant's Neme/Reletionship (Type, Print) (HUS)  REV. HERMAN A. diBRAND  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Onation 5 Other (Specity)  21. Signature of Funeral Service Licensee  William R. Jane College (1-40rt)  23a. Pert1. Enter the disease, or complications thet cause shock, or heart failure. List only one cause on each in the initiated events resulting in death)  Pert II. Other significant conditions contributing to death but a minimal decays (Fined disease or condition resulting in death) Last  25. Was cese referred to medical events resulting in death) Last  Pert II. Other significant conditions contributing to death but a minimal decays (Fined disease or condition resulting in death) Last  25. Was cese referred to medical events resulting in death) Last  26. Was cese referred to medical events resulting in death) Last  27. Manney of Death Last  28. Date of Injury that minimal devents resulting in death) Last  28. Date of Injury that minimal events resulting in death but of College (1-40rt) and the determined and the determ	APHRODITE V. diBRANDI  4e Fecility Neme (If not institution, give street end number)  GREATER BALTIMORE MEDICAL CENTER  5. Social Security Number  6. Sex  219-14-9049  10 M 2 F 7. Age (In yrs. lest b)  75  Usual Residence of Decedent  10a. Stete  10b. County  MD  BALTIMORE  TIMON  10c. City, Ton  MD  BALTIMORE  TIMON  10c. City, Ton  MD  BALTIMORE  TIMON  10c. City, Ton  MD  BALTIMORE  TIMON  10c. City, Ton  MD  BALTIMORE  TIMON  10c. City, Ton  MD  BALTIMORE  TIMON  10c. City, Ton  MD  10d. Street end Number  462 FIVE FARMS LANE  11. Marital Stetus  1	APHRODITE V. diBRANDI  4e Fecility Neme (If not institution, give street and number)  GREATER BALTIMORE MEDICAL CENTER  5. Social Security Number  6. Sex  219-14-9049  10	APHRODITE V. diBRANDI  4e Fecility Neme (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER  5. Social Security Number  6. Sex  7. Age (in yrs. kest brimday) 10c. city. Town or Location Months  10a. Stete 10b. County  MD BALTIMORE TIMONIUM  10c. Street and Number  462 FIVE FARMS LANE 11. Marital Stetus 11. Never Married 25 Married 31. Was Decedent Ever in U.S. 11. Never Married 25 Married 31. Stepechy only highest greds completed) 11. Sepechy only highest greds completed) 12. Fether's Name (First. Middle, Last) 12. Fether's Name (First. Middle, Last) 13. Was Decedent's Education 13. Stepechy only highest greds completed) 14. Pether's Name (First. Middle, Last) 15. Decedent's Education 15. Because (Insert Stepechy) 16. Decedent's Location 17. Fether's Name (First. Middle, Last) 18. VAE ILOU  19. Informant's Neme*Reletionship (Type, Print) (HUSBAND) 19. Mailing Address (Street-HOUSEWIFE) 19. 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Sex 7. 7.40e (if yrs. set frimdey)  100 Centre 1	APHRODITE V. diBRANDI  46 Febrilly Name (if not installation, give attreat and number)  46 Febrilly Name (if not installation, give attreat and number)  47 Febrilly Name (if not installation, give attreat and number)  48 Febrilly Name (if not installation, give attreat and number)  48 Febrilly Name (if not installation, give attreat and number)  49 City, Town, or Location of Death 48 Court Town or Location of Death 48 Court Town or Location of Death 48 Court Town or Location of Death 48 Court Town or Location of Death 48 Court Town or Location or Locat	APHRODITE V. diBRANDI  46. Poly, Town, color insulation, pive steered and number)  5. Social Sourty Name (if not insulation, pive steered and number)  5. Social Sourty Name (if not insulation, pive steered and number)  5. Social Sourty Name (if not insulation, pive steered and number)  5. Social Sourty Name (if not insulation)  5. Social Sourty Name (if not insulation)  6. 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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth A UG WT 70 1998 EPSTEIN **Physician** BETTY 4.30PM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner BALTIMORE RANDALI STOWN HOSPITAL NO (LTH WEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 J.F Yrs. Director 217-34-5498 92 FEB. 28, 1906 MARYLAND Usuel Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director BALTIMORE BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 6934 MILBROOK PARK DR., APT. 2-D 21215 USA Funeral 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) the Medical Examiner m Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene, other then Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME . Pages 1 and 2 should be filed viment of Health and Mental Hygie tant. If item 27 is marked other four yor other traumatic event, 13 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be MAX ALPERSTEIN FANNIE FURMAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) MELVIN D. EPSTEIN (SON) 4238 NADINE DR. BALTO., MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Deurial 2 Cremetion 3 Removel from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) BNAI ISRAEL 22. Name end Address of Facility 9/1/98 BALTIMORE, MD 21: Signature of Funeral Service License SOL LEVINSON & BROS., INC. 23a. ent. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximate Approximate Proximate ntervel Between Onset end Deeth Physician SEPSIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Examiner PNEUMONIA physician end s the buriel-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medicai Due to (or es e consequence of): 98 esn Pert II. Other elgnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Was en eutopsy performed? Completed certificate hes b irector, page 2 s 1 ☐ Yes 2 PONO 1 ☐ Yes 2 PNo 25. Wes case referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Phopatient 2 □ ER/Outpatient 3 □ DOA funeral 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28h Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After 1 Maturel 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Descripting Physicien: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier D37333 AUGUST 30,1998 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 5401 OLD COURT ROAD, BALTIMORE 21133 31. Dete filed (Month, Day, Yeer) SEP 0 3 1998 32. Registrar's Signeture State Registrar

DHMH 16 Bey 6/95



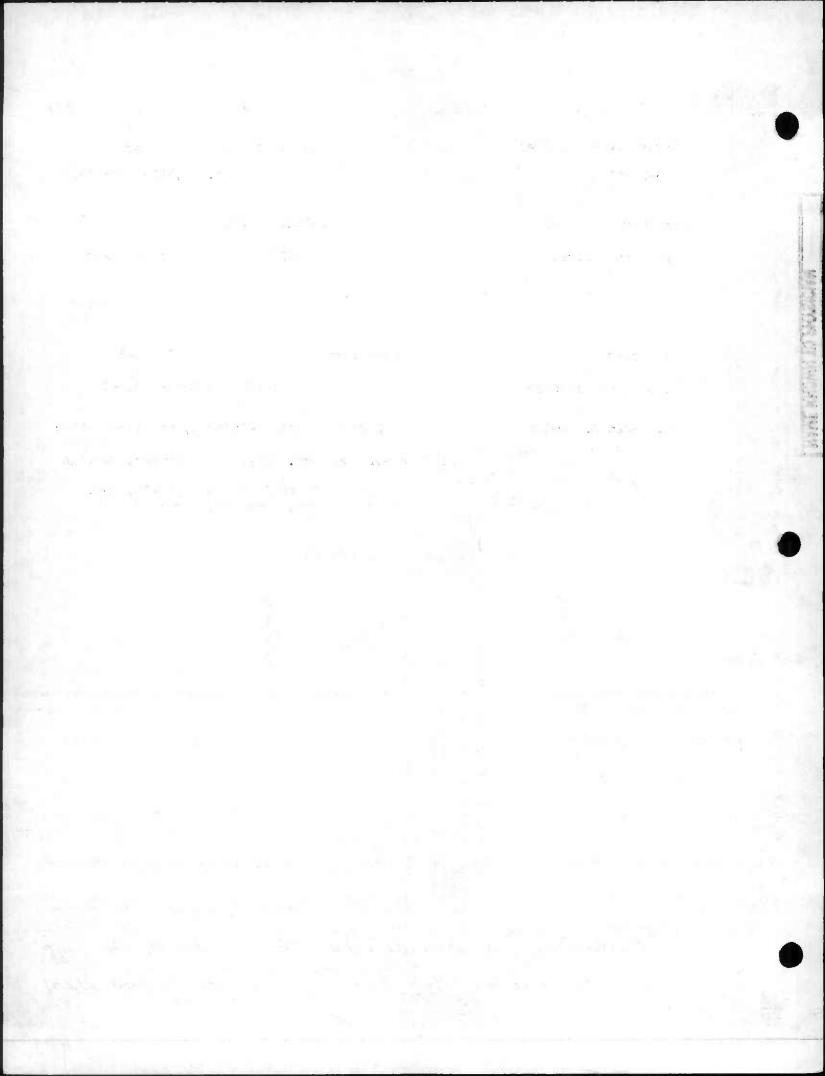
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-					Cel	tificate	ot i	Death			Reg. No.			
Physic /Medi		1. Decedent's Nama (First, Middle, SHAROM					2. Dete of De AUGUS	Day	Year 1998	3. Tima of Deeth 2020				
Examir		4a. Facility Nama (If not institution,	giva straat and nu	mber)			4	4b. City, To	wn, or L	ocation of Daa	th 4c. County	of Deeth		
		Church Home Hos	pital					Balt:	imor	e City		N/A		
Funeral		5. Social Security Number 6	S. Sex	7. Aga (In yrs.	lest birthday)	If Under 1 Y Months D	'aar ays	If Under:	24 Hrs. Min.	8 Date of Bi	eth	0 Rietho	iece (Stata or Foreign	
Director		216-34-8886	1□M 2⊠F	59	Yrs.	WOITE D	ays	Hours	IVIII I.	Dec.	15,1938	Mar	yland	
p ,		Usual Residence of Decedent												
anyla show	_	10a. State 10b. County		10c. Cr	ty, Town or Lo	cation						1	Od. Inside City Limits	
88-1	ct		I/A				I	Baltir	nore	City			1Æ Yes 2□No	
ith th	Director	10e. Street end Number				10f. Zip Co	da				10g. Citizen of \			
ours after death with the Manylan set, or items 23a or 28a-f show Exacticer must be notified at		306 Hornel Stre	et					2122	24		United States			
r der	Funeral	11. Marital Status	12. Was Dece	edant Ever in U prces?	,S. 13. V	Vas Decedent f Yes, specify	of H	lispanic Orig	gin? (Sp	ecify Yas or No Rican, etc.)	0- 14. Rac	e - Americ		
or it		1 Nevar Marriad 25 Marriad	d 1 ☐ Yes If Yes, Giv			□ Yes 2K								
ural',	d by	3 Widowed 4 Divorcad	Year or D	atas:							Specify	. W	hite	
2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other then "naturel", or flems 23s or 28s-f show reumatic avent, the Medical Exacuter mant be notified at	Completed	15. Decedant's (Specify only highest)	Education greda complatad)		16a. Deced (Give	lant's Usual O kind of work d OO NOT use re	ona d	etion du <i>nng</i> most	of work	ing	16b. Kind of B	usiness/Ind	lustry	
withir han	du	Elamantary/Secondery (0-12)	Collaga (1	1-4or 5+)				1)			01	7		
lled v tygie har t	ပိ	12 Years			S	ecreta:	ry	40.14.4		/F:	Cleri			
be f	Be	17. Father's Nama (First, Middla, La						18. Motha		a <i>(First, Middla</i> tha Cat				
Mer Marken Marken	2	Zerier Zerijanizi. Gzanian												
12 sk h end is n											er, City or Town,	Stete, Zip	Code)	
l end lealth m 27 har tr		Mr. James R. Fowler 306 Hornel Street  20a. Method of Disposition 20b. Place of Disposition (Neme of												
Peges 1 net: If Ita iry or ot		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3	☐Removal from	State	cemetery, crem	netory or other	pled		i	Date	20c. Location -	20c. Location - City or Town, State		
men men men mury		4 Donetion 5 Other (Specify) Hilltop Service Corp. 9/3  21. Signature of Futoral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral									Towso	n, Maryland		
permit. Peges 1 and 2 should be filed within 72 hours Department of Health end Mental Hygiene. Important: if Itam 27 Is marked other than "natural", any injury or other treumatic avent, tre Medical Exagnose.											Home of Dundalk, Inc.			
20599		Maen.	5,1	-							Marvlan	-	222	
-		23a. Part1. Enter the disperse, or co shock, or heart failure. List on	inclications that c	aused tha daat	h. Do not ante	er tha mode of	dyin	g, such as	cardiac	or respiratory	errest,	4	Approximata	
Physician		arriver, or result impage.	ny one ceuse on a	idon inid.									Interval Between Onset end Death	
/Medicai		immediata Cause (Finei disaase or condition	110	11-TIP	LEA	IVEL	2 1	11				1	3 Wieles.	
Examiner		resulting in deeth)  Due to (or as e consequence of):											Janey.	
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be executed cian end buriel-trensit	Examiner	Sequentially list conditions.	■ b. —											
an e		if any, leading to immadiate causa. Enter Undarlying												
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death ne etter ed for u	Physicia	Part il. Other significant conditions	contributing to de	eath but not res	ulting in tha un	derlying causa	a give	en In Part I.		23b. Did	tobacco usa co	ntribute to	the cause of death?	
by the esteched	h Y	Acute Ren	20 Fo	:0,						1 🗆	Yes 2000	3 Prob	ably 4 Unknown	
es thet Igned t be dete	by	- Marie rang	se / w	come					_					
The law requires thet the death tite has been signed by the etter bage 2 should be deteched for r	8									24a. Was	an eutopsy omed?		ere autopsy findings	
aw re	ple									perio	omiou!	cor	npletion of causa leath?	
The law ete hes page 2	Completed									10	Yes 200 No	10	Yes 200 No	
	Bec	25. Was case referred to medical					_	28 Place	of Death	(Check only				
or Attending Physician: after death. Director: After this certific in by the funerel director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitai:	npatient 2	ER/Outpatient	3□ DOA	Othe	or:			idence 6 □Oth	or /Specif		
ding Phys h. After this funerei di	-	27. Manner of Death	28e. Date o	of Injury	28b. Time of	28c.	Injury				how Injury occur			
ath. :: Aft	atio	1 Netural 5 ☐ Panding 2 ☐ Accidant Investigati		h, Dey Year)	Injury			k? Yes 2 □ N	No					
Attence or death octor:	Iffici	3 Suicida 6 Could not detarmine	286. Place	of Injury - At he	ome, farm, stra	et, factory, off	ice				Street end Numb	er or Rure	Route Number,	
S effe	Certification:	- I Hornida	buildir	ng, etc. (Spacify	y) ·					Uny or To	wn, Stete)			
To the Hospital or Attending P within 24 hours effer death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 1 Certifying F	Physicien: To tha	best of my kno	wiedge, daath	occurred at th	a tim	ne, date and	place,	and due to the	ceuse(s) and ma	nner as st	ated.	
in 24 in 24 in Ft	Medical	(Check only 2 Medical Exu	aminer: On the be end mann	isis of examinat	tion end/or Invi	astigation, in n	ny op	Olnion, daat	h occurr	ed et the tima,	data and plece,	end due to	the cause(s)	
To the Within 2 To the comple	×	29b. Signatura and title of certifier	( )					number			29d. Date signa			
		Wavarro ?	w. on	ed - Spe	ciolisi	1	4	0350	6		AUGUS	T 30	1990	
1		30. Name end addrass of person wh	o completed cause	e of death (Item	23a) (Typa, F	Print)	_		-	,			(118	
0			VARRO !	40. 1	00 N.	Broad	2w	aur.	Bal	Timor	e Mary	land	1998	
Sta	te	31. Date filed (Month, Day, Year)	32. Be		tura	,		0			0		77-01	
Registra		SEP 0 3 19	98	epera	19.	Span	6	/						
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NAME KNOWN TO PRINSICIAN

Baltimore, Maryland 21215-0020

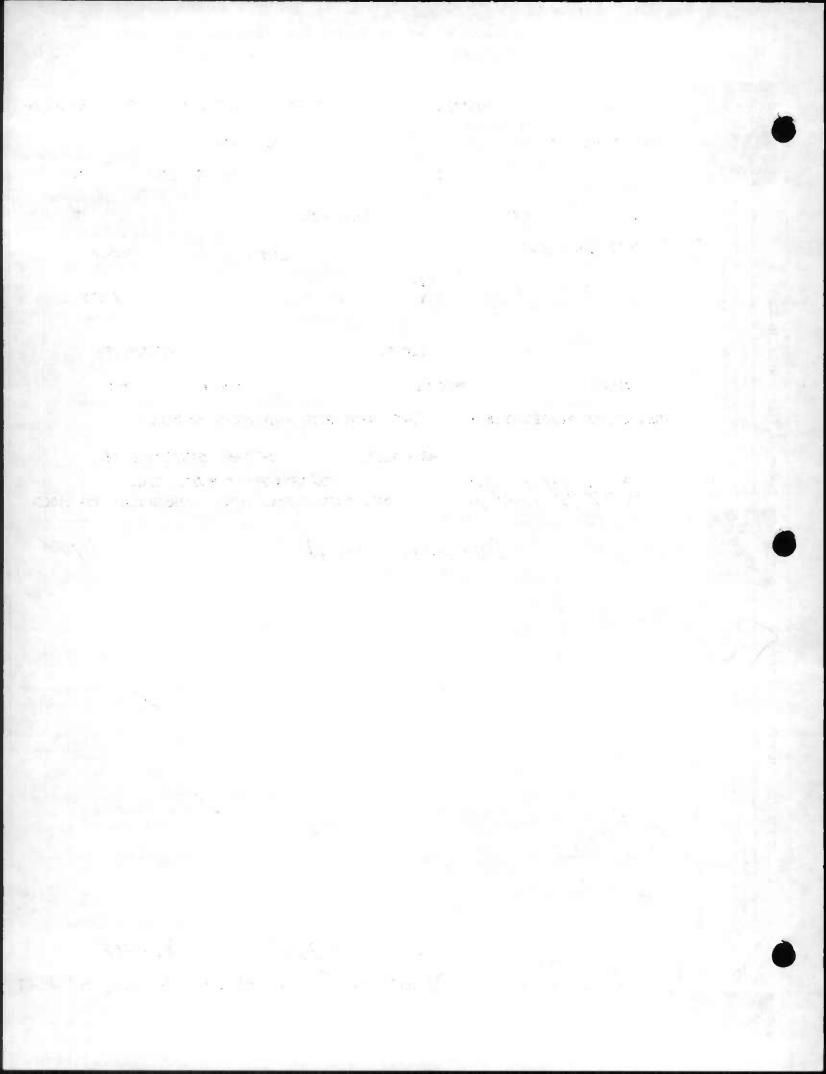
Division of Vital Records, P.O. Box 68760.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 26899

219–18–0541  al Residence of Decedent Stete 10b. County MD  Street and Number 2903 TANEY II  Marital Status Never Married 2 Married So Widowed 4 Divorced  15. Decedent's E (Specify only highest gitementary/Secondary (0-12)  Father's Neme (First, Middle, Las SAMUEL Informent's Name/Relationship	ROAD  12. Was Decedent E Armed Forces? IN Yes 2 IN If Yes, Give Year or Dates:  Education rade completed)  College (1-4or 5-4)  (Type, Print)  DIN (WIFE)	10c. City, Town Ever in U.S. WWII NAVY 16a.  FRADIN 19b. 20b. Place of	or Location  113. Was If Yes 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Under 1 Year onths Days  Days  Days  Days  Days  Days  Days  Days  Decedent of His, specify Cuba Yes 2 No s Usual Occup of work done of Work done of	If Under 24 Hrs. Hours Min.  ORE  2120: Ispenic Origin? (Sin, Mexican, Puert Specify: ation during most of world)  18. Mother's Nar	IMORE  8. Date of Birth (Month, Da) MAY 20  9 pecify Yes or Noo Rican, etc.)	10g. Citizen of V  14. Race Blee Specify  16b. Kind of Bu  ACCOUN	9. Birthpla. Country 10c What Country U.S.A. e - Americarck, White, etc. WHIT	MD d. Inside City Limits 1    Yes 2 □ No  y?  A •  In Indien, c.
2903 TANEY ROA  cial Security Number 219-18-0541  al Residence of Decedent  Stete 10b. County MD  Street and Number 2903 TANEY I  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Marital Status  Security only highest given only	N/A  ROAD  12. Was Decedent E Armed Forces? 12. Yes 2 In If Yes, Give Year or Dates: Education rade completed)  College (1-4or 5-4)  (Type, Print) DIN (WIFE)	73  10c. City, Town  ver in U.S. WWII NAVY  16a.  +) C.1  FRADIN  19b. 20	or Location  113. Was If Yes 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Under 1 Year Days  Days  DALTIM  Of. Zip Code  Decedent of His, specify Cuba Yes 2x No  s Usual Occup of work done of	BALT  If Under 24 Hrs. Hours Min.  ORE  2120  Ispenic Origin? (Sin, Mexican, Puert Specify: attion furing most of world)  18. Mother's Nar	IMORE  8. Date of Birth (Month, Da)  MAY 20  9 pecify Yes or No- o Rican, etc.)	10g. Citizen of V  14. Race Blee Specify  16b. Kind of Bu  ACCOUN	N/A  9. Birthpla Country  10c  What Country  U.S.A  9. American  K, White, etc.  WHIT  usiness/Indu	MD d. Inside City Limits 1   Yes 2 □ No  y?  A •  In Indien, c.
cocial Security Number 219–18–0541  al Residence of Decedent Stete 10b. County MD  Street and Number 2903 TANEY If Marital Status   Never Married 2 Married	N/A  ROAD  12. Was Decedent E Armed Forces? 1X Yes 2 N If Yes, Give Year or Dates: Education rade completed)  College (1-4or 5-4)  (Type, Print) DIN (WIFE)  Removal from State sity)	73  10c. City, Town  ver in U.S. WWII NAVY  16a.  +) C.1  FRADIN  19b. 20	or Location  113. Was If Yes 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Develon  BALTIM  Of. Zip Code  Decedent of His, specify Cuba  Yes 2 No  s Usual Occupy of work done of NOT use retired	If Under 24 Hrs. Hours Min.  ORE  2120: Ispenic Origin? (Sin, Mexican, Puert Specify: ation during most of world)  18. Mother's Nar	8. Date of Birti (Month, Da) MAY 20  9 pecify Yes or No- on Rican, etc.)	10g. Citizen of V  14. Race Blee Specify  16b. Kind of Bu  ACCOUN  Maiden Sumam	9. Birthpla Country 10c What Country U.S.A e - Americanch, White, etc. WHIT usiness/Indu	MD d. Inside City Limits 1   Yes 2 □ No  y?  A •  In Indien, c.
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MD  Street and Number 2903 TANEY F  Marital Status  Never Married 2 Married Widowed 4 Divorced  15. Decedent's E (Specify only highest gi ementary/Secondary (0-12)  Father's Neme (First, Middle, Las  SAMUEL  Informent's Name/Relationship MRS LILYON FRA  Method of Disposition	ROAD  12. Was Decedent E Armed Forces?  12. Yes 2 Not Fee, Give Year or Dates:  Education rade completed)  College (1-4or 5-4)  (Type, Print)  DIN (WIFE)  Removal from State sity)	ever in U.S. WWII NAVY  16a.  C.I  FRADIN  19b. 29	13. Was If Yes 1 Decedent's Constant of the Co	BALTIM  Of. Zip Code  Decedent of His, specify Cuba  Yes 2√ No  S Usual Occupy of work done of work done of work done of the specified of the	2120: ispenic Origin? (S in, Mexican, Puert Specify: ation furing most of wor )  18. Mother's Nar	pecify Yes or No- o Rican, etc.)	14. Raci Blec Specify 16b. Kind of Bu ACCOUN Maiden Surnam	What Country U.S.A e - American ck, White, et WHIT usiness/Indu	1 to Yes 2 □ No y?  A • n Indien, c.
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Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	□Removal from State	20b. Place of	MRS. LILYON FRADIN (WIFE) 2903 TANEY ROAD BALTI						Code)
1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	eity)	20b. Place of		ANEY RO	AD BALTI	MORE, MI	21209		
Signeture of uneral Service Lice	ansee		Disposition v, cremeto ISRA	ry or other plac		Date 0-98 B7	20c. Location -		m, State
n. Part1. Enter the diseese, or conshock, or heart failure. List only mediate Cause (Final pase or condition afting in death)  Junetielly list conditions, by leading to immediate se. Enter Underlying ise (Disease or injury Initiated events alting in death) Last	a. CAR	Due to (or as a co	890 ot enter th	O REIST The mode of dyin  Co Lo N  Co Co I  Co of):  Co of):	J	ROAD c or respiratory et  23b. Did  1   24a. Wes perfo	PIKESVII rest,  tobacco use co Yes 2 D No en autopsy omed?	ntribute to 0 3 Probe	AD 21208 Approximate interval Between Donset and Death  White cause of death  ably 4 unknow  The autopsy findings liable prior to piletion of cause eath?  Yes 2 No
Was case referred to medical					26 Place of De		/		103 20110
examiner?	Hospital: 1   Inpatie	nt 2 TFR/Ou	tpatient 5	DOA Oth	OF:			ner (Specify)	
27. Magner of Death   1									
. Certifier Check only one) Certifying P	sminer: On the basis of	examination and	, death occ	curred at the tin igation, In my o	ne, date and piece pinion, death occ	e, and due to the urred et the time,	cause(s) and madate and place,	anner as sta and due to t	ited. the cause(s)
. Signeture end title of certifier		29d. Date signe	ed (Month, D	Day, Year)					
A		0/-1	0/10						
posem	10 Mar	111		V	JUST		0/10	148	
No. of the state o	was case referred to medical investigation.  Was case referred to medical examiner?  II. Other algnificant conditions  Was case referred to medical examiner?  III. Other algnificant conditions  Was case referred to medical investigation in the standard investigation i	was case referred to medical examiner?  II. Other algnificant conditions contributing to death but the same and address of person who completed cause of death and manner states the same and address of person who completed cause of death and manner states the same and address of person who completed cause of death and manner states and	Assertion (Iting in death)  a. Due to (or as a contribution of the property of	Avas case referred to medical examiner?  II. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner?  III. Other significant conditions contributing to death but not resulting in the under examiner.  III. Other significant conditions contributing to death but not resulting in the under examiner.  III. Other significant conditions contributing to death but not resulting in the under examiner.  III. Other significant conditions contributing to death but not resulting in the under examiner.  III. Other significant conditions contributing	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequence of):    Due to (or as a consequence of):	uentielly list conditions, y, leading to immediate se. Enter Underfying se (Disease or injury infliated events litting in death) Last    Due to (or as a consequence of):	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequence of):    Due to (or as a consequence of):



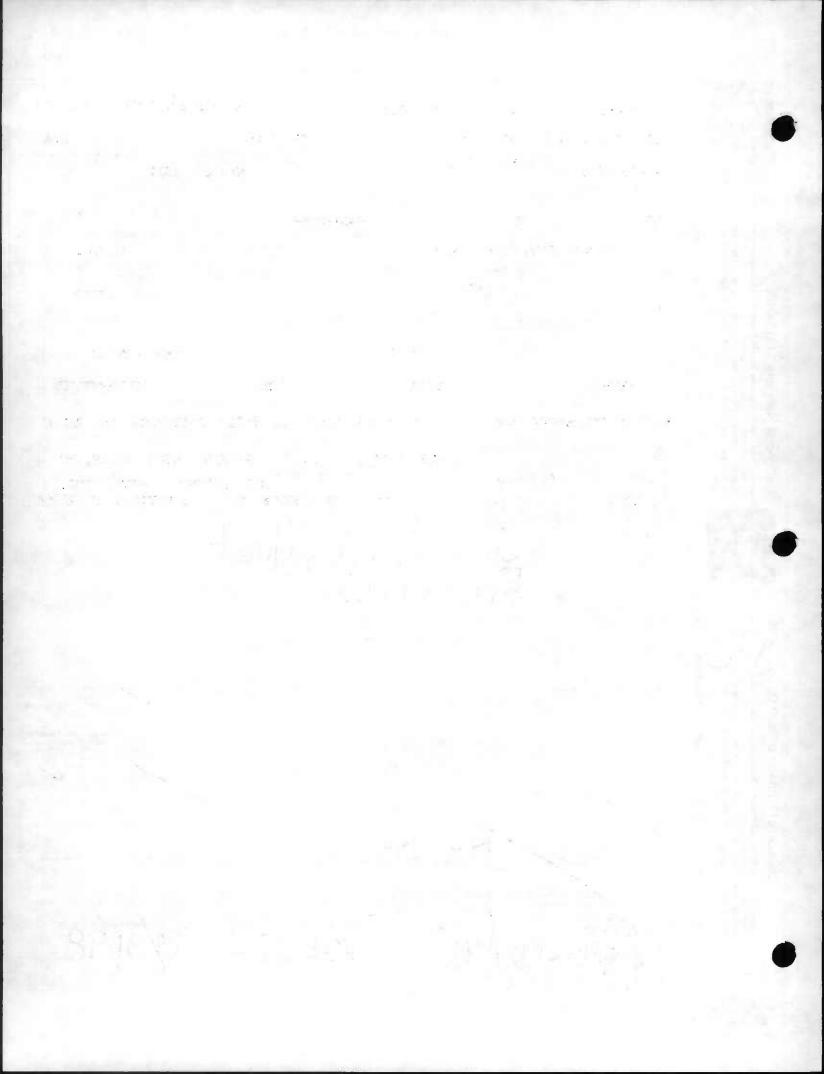
State of Maryland / Department of Health and Mental Hygiene

26900

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dele of Deeth 3. Time of Death Month Day **Physician** AUGUST 30, 1998 5:05 PM RACHEL FELDSTEIN /Medical 4e Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 111 HAMLET HILL ROAD #810 BALTIMORE N/A If Undar 1 Yaar Birthpleca (Stete or Foreign Country) 5. Sociel Sacurity Number If Undar 24 Hrs. 7. Aga (In vrs. last birthday) 8. Dele of Birth (Month, Dey, Year) **Funeral** Months 1□M aX F Deys Hours 218-36-9434 86 MAY 24, 1912 Director TN Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. inside City Limits 10e State 10b Counts 7 is marked other than "naturel", or frems 23a or 28a-f show traumatic event, the Medical Examinor must be notified at XYes 2 No Director MD N/A BALTIMORE 10g. Citizen of Whet Country? 10e, Street end Number 10f. Zip Code 111 HAMLET HILL ROAD #810 21210 U.S.A. Funeral death 13. Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status 12. Was Decedant Ever in U,S. Armed Forces? Bleck, White, etc. filed within 72 hours after 1 ☐ Yas ②CMNo If Yes, Give Yaer or Detes: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE þ 3€Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ OWNER REAL ESTATE 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) . Peges 1 end 2 should be filk ment of Heelth and Mental Hy lant: If Item 27 is marked oth jury or other traumatic event Be **ABRAHAM OCHSTEIN** ROSE SCHWARTZBAUM 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) RICHARD FELDSTEIN (SON) 111 HAMLET HILL ROAD #1210 BALTIMORE, MD 21210 20b. Placa of Disposition (Nema of cemetery, crematory or othar place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 

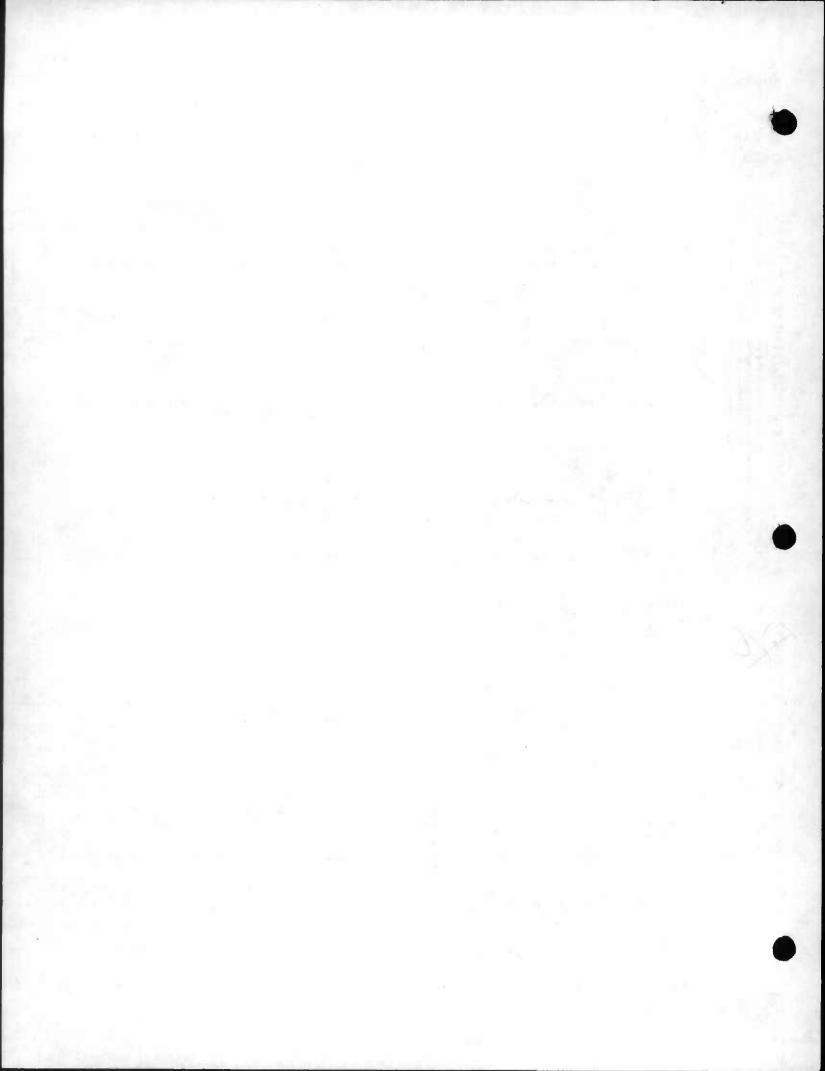
Buriel 2 □ Cremation 3 □ Ramoval from State
□ Donetion 5 □ Other (Specify) permit. Pege Depertment of Important: If any Injury or HAR SINAI CEMETERY 9/1/98 OWINGS MILLS, MD 22. Name end Address of Facility 21. Signeture of Funeral Service Liq SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximata Intervel Between Onset and Deeth the diseese, or complications and call eart failure. List only one cause on eart **Physician** /Medical Immediate Cause (Final 116010 Examiner Examiner Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest 68760 edical Due to (or as a consequence of) Physician/M Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ed by the 1 Yes 2 No 3 Probably 4 Unknown signed i A 24b. Ware eutopsy findings available prior to complation of causa of deeth? Completed 24a. Wes an autopsy page 2 1 ☐ Yes 2 ☐ No 1 Yas certificete 25. Was case referred to medical examiner? Attending Physician: director Be 28. Piece of Deeth (Check only ) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 21 No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending M 1 Yes 2 No A Investigation 2 Accident efter deet Diractor: 6 Could not by 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital or Filled 24 hours To the Hosp within 24 hou To the Funer completely fil 29a. Certifie 1 Certifying Physician: To the lest of my knowledge, deeth occurred et the time, date end plece, end due to tha cause(s) end menner es steted Medical (Check only one) Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha time, date end place, end due to the cause(s) and marker stated. 29b. Signaty Licensa number to signed /Mon 3e) (Type, Print) 31. Deta filed (Month, Day, Year) 32. Pegistrai State 0 3 1998 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 9 8 9 6 9 0 1

							Reg. No.			
1. Decedant's Nama (First, Middla, La	est)	1.5	7,144			2. Data of De	eath Day	3. Tima of		
Elzie RAV	Fritt	-5				Seistem	/	1998 01.2		
4a Facility Nama (If not institution, gir	va street and number)	CL 80		4	b. City, Town, o	r Location of Deat	h 4c. County	of Death		
Harbor Hos	pital				Balti	more	Baltin	more City		
5. Social Security Number 6. 5	Sax 7. Aga	(In yrs. last birt		der 1 Year	If Under 24 Hr	s. 6. Data of Bir	th	9. Birthplaca (Stata o		
579-16-4028		76	Yrs. Month	ns Days	Hours Min	n. (Month, De	1, 1922	Tennessee		
Usual Rasidanca of Decedant										
10a. Stata 10b. County		10c. City, Town	or Location	111				10d. Inside Ci		
Maryland Anne Ar	unde1	Glen	Burnie	2			1 ☐ Yas			
10e. Street and Number			401 *	Zip Code			10g. Citizen of What Country?			
211 N Street, S.E				21061			10g. Citizen of What Country? United States			
11. Marital Status	12. Was Decedant Ev Armed Forcas?		13. Was Dec	cedent of H pecify Cuba	ispanic Origin? ( in, Mexican, Pus	(Specify Yas or No arto Rican, atc.)	Black	Amarican Indian, k, Whita, atc.		
1 Nevar Married 2 Married	1 ⊠ Yas 2 □ No If Yas, Giva		1 ☐ Yes	2 № No	Specify:					
3 Widowed 4 Divorced	Yaar or Datas:	1942-43					Specify: White			
15. Decedent's E (Specify only highast gro		16a.	Decedent's Us	suat Occup	ation during most of w f)	ndrina	16b. Kind of Business/Industry			
Elemantary/Secondary (0-12)	Collega (1-4or 5+)	1		Tuse retired	)	orning .				
7		Med	chanic				Dairy			
17. Fathar's Nama (First, Middla, Last	"				18. Mothar's No	ama (First, Middle	, Maiden Sumam	в)		
John Fritts					Nettie	Frances	es DuVall			
19a. Informant's Name/Ralationship	(Type Print)	105	Mailing Added	ass /Strant	and Number or I	Rural Pouts Numb	umber, City or Town, Stata, Zip Code)			
Norma Jean Fritts		21	1 N Str	ceet,	S.E., G	len Burn	ie, Mary	, Maryland 21061		
		OOb Diese of	Disposition (A	Name of		Data 1	200 1	Cit T Ct-t-		
20a. Mathod of Disposition  1  Burial 2 □ Cramation 3 □	Ramoval from Stata	cematar	y, cramatory o	or othar plac	e)	Sept. 4	City or Town, Stata			
4 Donation 5 Other (Specia		Glen H	laven M	lem. P	k.	1998	urnie, Mar			
21. Signature of Fungat Service Lice	nsee		22. Name	and Addra	ss of Facility	uneral H				
1 / Nu 1/1	10									
23a. Part1. Entar tha disaasa, or corr shock, or haart failura. List only	~~					.E., Gle		Approximate		
resulting in death)		a CVAI		of):	lemor	rhage		1		
	b		consequence o	of):	lemor	rhage				
	b	lua to (or as a c	consequence o	of):	lemor	rhage				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Certificat	e of Deati	h	Re	g. No.		
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		Williamsport Nu	ursing Home			Will:	iamsport		Wash:	ingto	n Co.
Funera	1	5. Sociel Security Number		Age (In yrs. lesi	t birthday) If Under Months	1 Year If Under	Min. 8. D	ete of Birth fonth, Day,			lece (State or Foreign try)
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending payallan completely filled in by the funeral director, page 2 should be detached for use as the business the business the business the business the business the business than business the business than business th	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pert II. Other significant conditions are summer?  25. Wes case referred to medical examiner?  1 Yes 2 No  27. Menner of Death 1 Naturel 5 Pendia investing Naturel 5 Could determ 1 Could determ 1 Check only one)  29s. Certifier (Check only one)  29b. Signeture end title of certifier	d	Due to (or estable to for estable to for estable to for estable to for estable to for estable to for estable to for estable to for estable to for estable to for examinetion stated.	s e consequence of): s e consequence of): s e consequence of): s e consequence of): ng In the underlying consequence of):  WOutpetient 3 DO Do. Time of Injury M e, ferm, street, fectory adge, death occurred of the end/or investigetion, 29c Daa) (Type, Print)	26. Ple  26. Ple  27. Other: 4 1 1 2 2 2 2 3 2 3 2 3 3 3 3 3 3 3 3 3 3	ce of Deeth (Che Nursing Home 28d. I	1 Yes  24a. Wes an perform  1 Yes  2ck only one  5 Resider  Describe how  ocation (String) or Town,  ue to the cetthe time, data	eutopsy ed?  s	24b. We ave cor of the correct of th	o the cause of death?  pably 4 Unknown  ore autopsy findings aliable prior to mpletion of cause death?  Yes 2 No  No  No  Route Number,  leted. the cause(s)  Dey, Year)

WE SEE TO THE SEE 

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** GREGORY AUGUST 30 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Daath Examiner UNIVER IT OF MARYLAND MEDICAL SYSTEM RACTIMORE BALTIMORE 6. Sax 1 AM 2 ☐ F 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) **Funeral** Months Davs Hours Director 214-50-4625 23 50 MD Usual Rasidance of Dacedant the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 X Yas 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? "naturel", or items 23s or death with U.S.A.
14. Raca - Amarican Indian, 2 South Woodington Road Apt Al 21229 Funeral 12. Was Dacedant Evar In U.S. Armed Forcas? 1 ☐ Yas 2 2 No If Yas, Giva Yaar or Datas: Was Dacadant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, etc.) Black, Whita, atc. filed within 72 hours efter of Hygiene. 1 ☐ Navar Married 2 ☑ Married 1 ☐ Yas 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed h end Mentel Hygiene.
7 le marked other than "natur traumatic event, tre Medical 16a. Decedant's Usual Occupation (Giva kind of work do na during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) 9th grade 17. Fathar's Nama (First, Middla, Last) Self Employed Self Employed na permit. Peges 1 end 2 should be file Department of Health end Mentel Hy, Important: If Nem 27 le marked othe any Injury or other traumatic event, once. 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Willie Gregory Sr.
19a. Informant's Name/Relationship (Typa, Print) Lottie Lee

19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Beverly Gregory-Wife 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, crematory or other place)

8851 Fontana Lane, Baltimore Md 21237

Data 20c. Location - City or Town, Stata 1 Burlat 2 Cramation 3 Ramoval from Stata 4 □ Donation 5 □ Other (Spacify) Arbutus Memorial 9/5/98 Arbutus, Md 21. Signatura of Furgaral Service Licenses 22. Nama and Addrass of Facility March F/H West
4300 Wabash Ave, Baltimore Md 21215

Approximata shock, or has it failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final SEPTICEMIC SHOCK disaasa or condition rasulting in daath) Examine Examiner UNDIFFERENTIMED LEUKEMIA Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequance of): Physician/Medicai Dua to (or as a consequence of) Division of Vital Records, P.O. Box 23b. Did tobecco use contribute to the cause of death? Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. signed by t 1 Yes 2 No 3 □ Probably 4 Unknown by 24b. Were autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy Completed ils certificate hes I director, page 2 1 Yas 2□No 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to medicat axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this After this funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 2 Accidant 5 Panding death. 1 Yas 2 No Invastigation within 24 hours after death To the Funeral Director: / completely tilled in by the 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifiar Medical (Check only one) the 29b. Signature 29c. Licansa number 29d. Date signed (Month, Day, Year) 2 AVY17645E9222 AUGUST 30,1998 address of person who complated causa of death (ttam 23a) (Type, Print) 30. Name and 22 S. GREBUE ST, BALTHORE, MD 21201 MICHOEL EBRIGHT, MD

State

Registrar

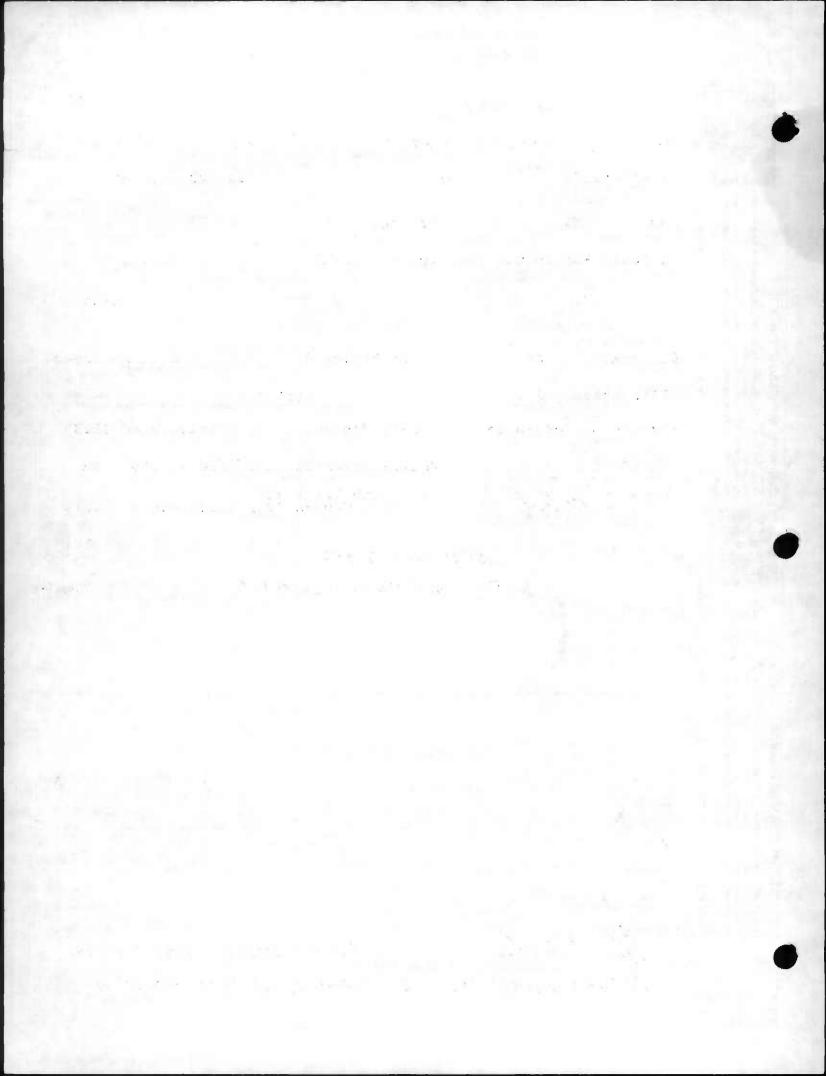
31. Date filed (Month, Day, Yaar)

SEP 0 3 1998

32. Registrar's Signatura

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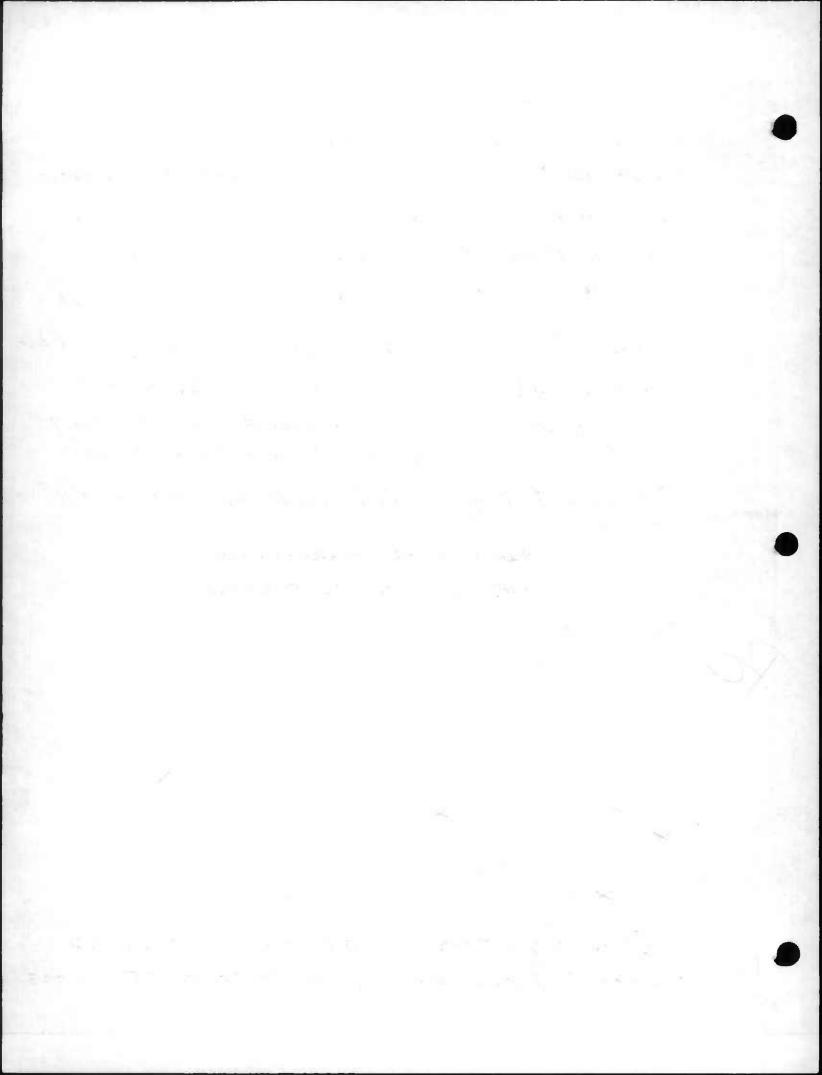


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Moulth **Physician** PARENCE 10,20 AN GIENN 30 /Medical 4a. Fecliity Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 2000 W. **Examiner** BAHIMORE SA HIMORCE

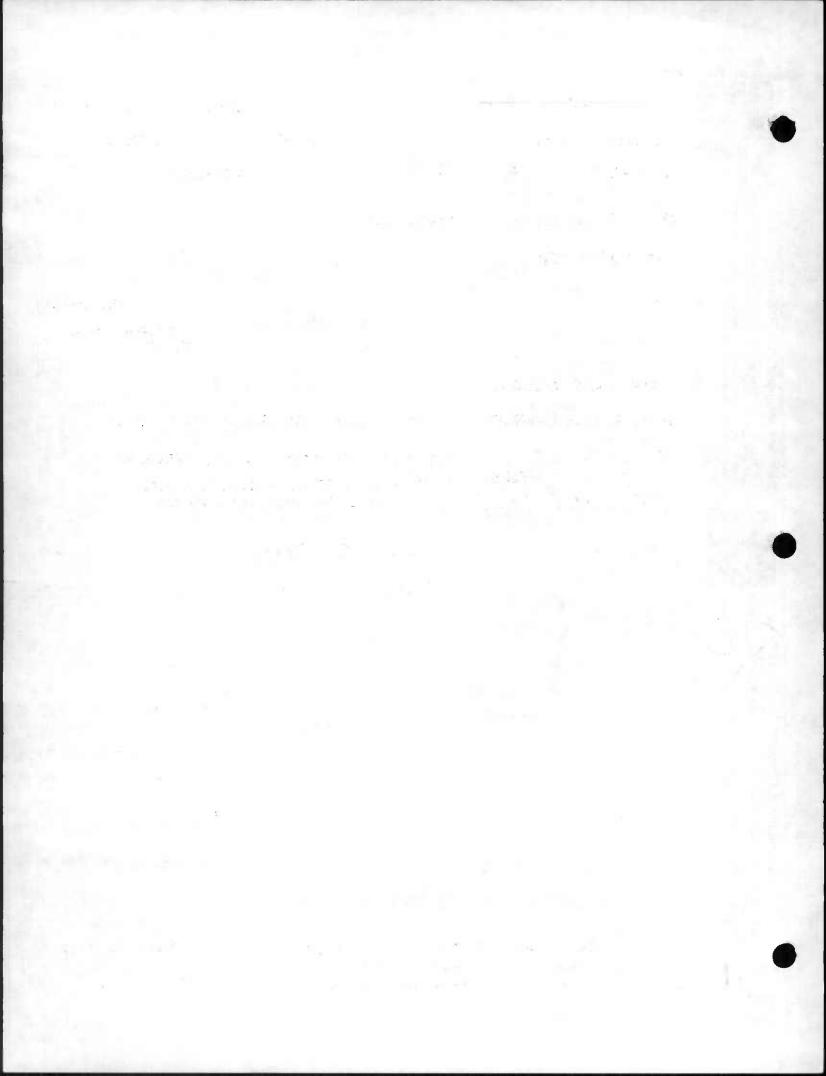
If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Yeer) Maryland Securs tosptal BAHIMAREST 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1**2** M 2□ F 34 4488A 63 Yrs. Director ARKANSAS 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show Ballo Director N. A 1 Yes 2 No Md 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò STRICKEL ST 1009 21217 4-5. items 23e Funerai 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. treumstic event, the Medical Examiner 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yes 2 No Black þ Specify. 3 ☐ Widowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Health and Mantal Hygians (important: If flem 27 is marked other than eny Injury or other treumetic access.) Elementery/Secondary (0-12) College (1-4or 5+) CHESOPERE TRUCK DHIVER 5 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) PRICELLA 5 PENCBF Sr. LARENCE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Salto-mi 1009 hi DTruker MARIC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 9/7/98 RM 13 Mcommount 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee Juneral Home 1304 n. Central of Locks docks 23e. Pert / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervei Between Onset end Death **Physician** /Medical Immediate Cause (Final VENTRICULAR diseese or condition resulting in death) **Examiner** Physician/Medical Examiner RENAL DISEASE be axecuted Sequentiely list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest and Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. O. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed 1 Yes 2 No Division of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 R/Outpetient 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred affer death. After 5 Pending investigation Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, end due to the ceuse(s) end manner stated. 29a. Certifier Medicai 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D31993 09-01-98 completed cause of deeth (Item 23e) (Type, Print) ZOOO W BALTIMORE ST. BOLGIANO 21223 2. Registrer's Signature State Registrar



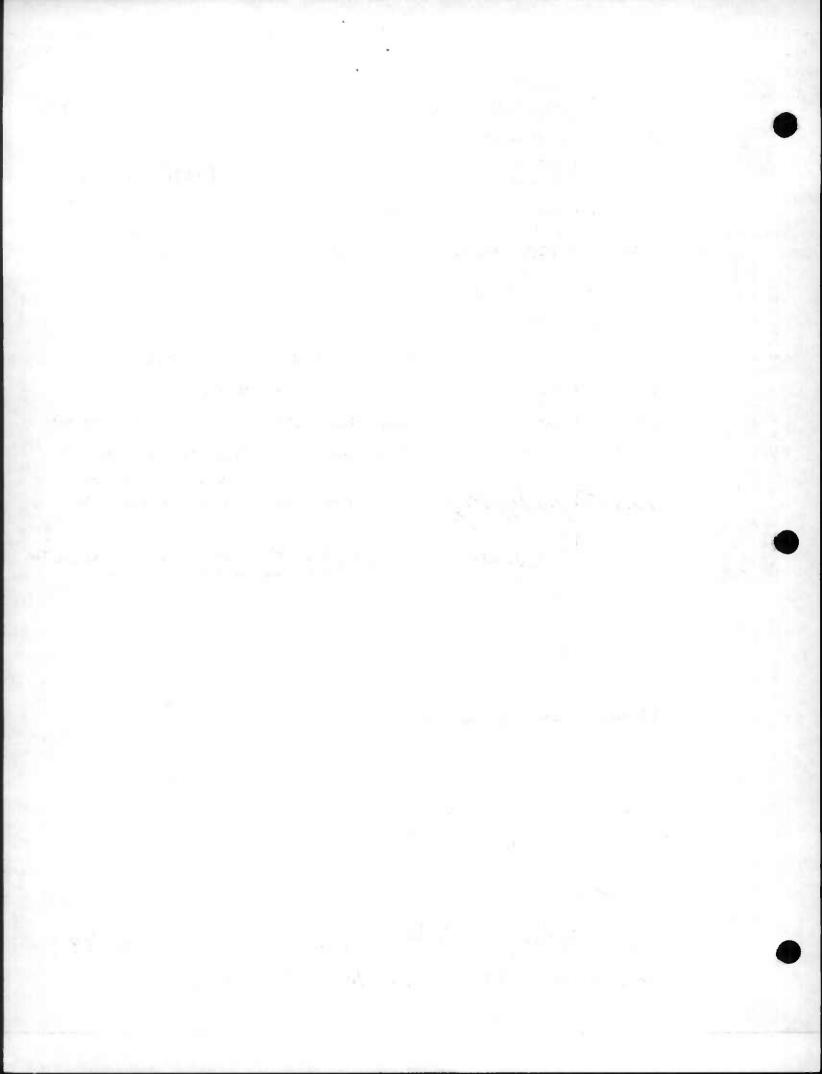
#1 Per MD	Film G763 9-24-98RC  1. Decedent's Name (First, Middle, La	2. Dete of De	Reg. No.	3. Time of Deeth							
Physician /Medical	CORA VIRGINIA		ORA VIRGIN	IA GOSLEE		SEPT.	Dey 1, 19	98 12:45 PM			
Examiner	4e Facility Neme (If not institution, giv 4924 LOCKARD DRIV				4b. City, Town, or Lo		4c. County of BALTO				
uneral	Social Security Number     6. S	iex 7. Age (II	yrs. last birthday)	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Date of Bir (Month, De	th y, Year)	Birthplece (State or Fore Country)			
irector	218-16-7156 Usuel Residence of Decedent	□м 270 F	84 Yrs.			4-27-1	914	MD			
show	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Lim			
or 28a-f show	MD BALTO. CO	).	OWINGS M	10f. Zip Code			10g. Citizen of W	t)( Yes 2 1			
0 8 0	4924 LOCKARD DRIV	/F		21117			U.S.A.	mot obanny i			
oral Example must be notified at	11. Marital Status  1 Never Married 2 Married  3 N Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2 Xoo If Yes, Give Yeer or Dates:			Hispanic Origin? (Specian, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race Blace	Arrange - American Indien, k, White, etc.			
	15. Decedent's Ed	ducetion	16a. Deced	lent's Usuel Occu	pation during most of work	ina	siness/Industry				
omp	(Specify only highest gra	College (1-4or 5+) 5+	TEA(	OO NOT use retire	9d)		SYSTEM	D SCHOOL			
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7 is m traum	19e. Informent's Name/Reletionship ( JANNAI GOSLLEE (I				DRIVE OWI						
f Hoal tem 2 other	20e. Method of Disposition	1	Plece of Dispo			Date		City or Town, Stete			
uny or o	1 Buriel 2 Cremetion 3 C 4 Donetion 5 Other (Specif	Removel from State			GARDEN 9-	5-1998	HEBRON	MD			
E 6 2	21. Signatura of Puneral Service Licer	EUGENE N	WALKER 22	Name end Addr STEP BRO	ess of Fecility THERS FUNE	RAL HO	ME P.A.				
3100	- Jugan Hall	Mill	13	300 EUTA	W PLACE BA	LTO. MI	D 21217	Approximete			
ysician	23a. Fartt. Enter the disease, or com shoot, or heart failure. List only	ope causyon each line.	Januari. Boriot Grit	or the mode of dy	ang, sour os cordias	or reapprotery e	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Intervel Between Onset end Deeth			
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	27. Manner of Deeth  1 Phaturel 5 Pending 2 Accident Investigatio	28e. Dete of Injury (Month, Day Yo		28c. fnji			how injury occurr	. , . ,,			
SEE E	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (S	- At home, ferm, str Specify)	eet, fectory, office	9	28f. Location ( City or To	(Street end Numb wn, Stete)	er or Rural Route Number,			
meral of tilled by tilled call Ce	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of m miner: On the basis of ex end menner stated	amination end/or in	n occurred et the vestigetion, in my	time, dete end plece, opinion, deeth occur	end due to the red et the time,	cause(s) end me date end plece,	enner es steted. end due to the ceuse(s)			
25분 등	end menner stated.  29b. Signature end title of certifier  29c. License number  29d. Dete signed										
Within 24 To the Fo complete Medic	230. Signatore end title of certifier	037573									
within 24 To the Fs complete Medic	250. Signature end title of certifier	-		D'	37573		Selen	3,1998			
within 24 To the Fu complete Medic	30. Name and address of perion who	completed ceuse of deet	h (Item 23e) (Type,		37573 re Bal		MD 7	3,1998			

DHMH 16 Rev 6/95



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26906

				Cert	ificate of	Death	R	eg. No.		700				
Physician		Decedant's Nama (First, Middle, Last)	60	0	11		2. Date of Dea Month	th Day	Year	3. Tima of Death				
/Medical	1	EUGENE WALTER		LAC	HER		80	31	98	0955				
Examiner	r	la. Facility Nama (If not institution, give street and numb Good Samavi Tan H		/		BACTIM	Location of Death	4c. County	of Death					
Funeral Director			Aga (In yrs. la	st birthday)	If Undar 1 Yaa Months Days	If Undar 24 Hrs	8. Date of Birth	Year)		aca (Stata or Foraig				
p <sub>c</sub>	-	Jsual Rasidanca of Decedent							Mary					
the Marylan 28a-f show nortified at		MD Baltimore		Town or Loca timore	ation				10	od. Insida City Limits				
23a or	al Dire	Oe. Street and Number 25 Fullerton Heights Av	enue		10f. Zip Coda 212	236	1	0g. Citizan of V		ry?				
urs efter al', or its Examine	2	1. Marital Status  1 □ Navar Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decede Armed Force  1 □ Yas 2  If Yas, Giva Yaar or Date	is? No		as Decedant of Yas, specify Cul		Specify Yas or No- rto Rican, atc.)	Blad		a - Amarican Indian, k, Whita, atc. White				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Esella 4b. City, Town, or Location of Death 4c. County of Death :34 4a Facility Name (If not institution, give street and number) But more City.

H Under 24 Hrs. 8. Date of Birth Month, Day, Year)

Min. Min. 33 7. Ade (In yrs. last birthday)
65 Yrs. Hookins The Johns 5. Social Security Number 6. Sex If Under 1 Year Birthplace (State or Foreign Country) Months Days 1 M 2 F NIA Bernude Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Bermuda Island Boaz 1 | Yes 2 | 1√6 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Close malabar #10 M. A01 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married specity: Black 1 Yes 2 PNo Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) N/A Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser- Seams tres 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Knight Simons Grandville #10 Malabar Close, Boaz Island, Sands Burmuda ace of Disposition (Name of 19a. Informant's Name/Relationship (Type, Print) Charlene Gilbert 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State James Church CEM Bermuda 9-8-98 Sands, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Liceosee Salma North March F. H 1101 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata tritarval Batween Onset and Death Immediate Cause (Final disease or condition resulting in death) asysple Zmin Dua to (or as a consequence of): Coronary Due to (or as a consequence of): Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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10a. State

**Funeral** 

Director

d 2 should be filled within 72 hours aftar death with the Maryland and Maniel Hyglen.
7 Is marked other than "natural", or items 23s or 28s-f show traumatic event, the second control of the profiled at

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permit. Page Department of important: If any injury or page.

Baitlmore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records,

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After this

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Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last by

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25. Was casa referred to medicat examiner?

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2 Accident 3 ☐ Suicide

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(Check only one)

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SEP 0 3 1998

24 hours after death. Hospital Medical 29a. Certifier within 24 hor To the Fune complataly fi To the 29b. Signature and title of certified 31. Date filed (Month, Day, Year) State

Physician/Medical Examiner Certification: To

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28a. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

24a. Was an autopsy performed?

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

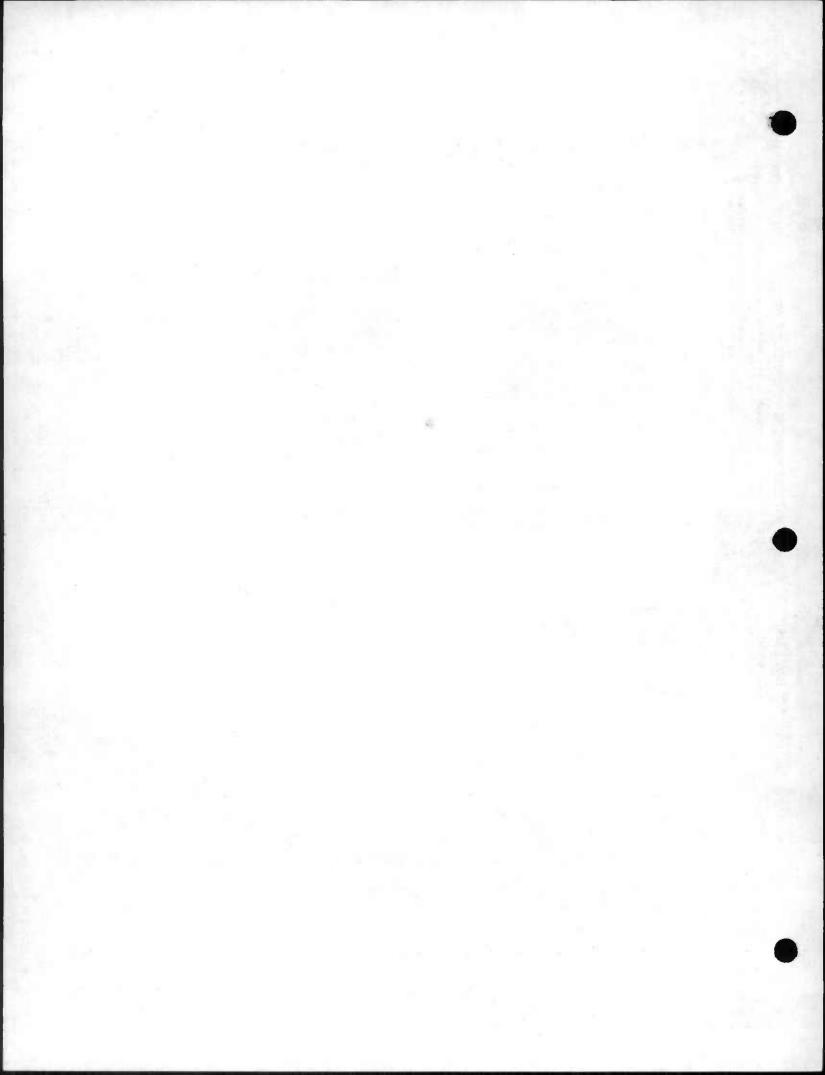
1 □ Yes 2 No

ullen M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) bec mit

32. Registrar's Signatura

Registrar



State of Maryland / Department of Health and Mental Hygiene

BESSIE C. GOLDSMITH Certificate of Death Reg. No. 3. Time of Death 2. Data of Daeth 1. Decedant's Nama (First, Middle, Last) Month Day Yee **Physician** Dold Smit ressiver 1 38 40 4k /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, give street end number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Undar 1 Year If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 M 2 K F Yrs 217-26-0372 87 1911 BOSTON, JAN. 1, **Director** Usual Rasidanca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23s or 28s-f shov the Medical Examiner must be notified at 1 Yas 2 No BALTIMORE BALTIMORE Directo 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 3613 CORONADO ROAD 21244 U.S.A. Funeral filed within 72 hours efter deeth Hygiene. 12. Was Decedent Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Give Yeer or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Merital Status Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Spacify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Dacedant's Usual Occupation 16b. Kind of Businass/Industry 15. Dacadant's Education (Specify only highast grada complated) (Giva kind of work dona during most of working life. DO NOT usa retired) Collega (1-4or 5+) Elementery/Secondery (0-12) TEACHER EDUCATION 18. Mother's Nema (First, Middle, Maiden Sumama) 17. Fathar's Neme (First, Middle, Last) Be permit. Peges 1 and 2 should be Department of Heelth and Mental Important: If item 27 is marked o JOSEPH CUMMINS SARAH COHEN 0 19b. Malling Addrass (Street and Numbar or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raletionship (Typa, Print) WILLA CUMMINS (SIS-IN-LAW) 3801 SCHNAPER DRIVE #431 RANDALLSTOWN, MD 21133 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☑Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 9 injury MOSES MONTEFIORE WOODMOOR 9/1/98 BALTIMORE, MD 22. Nama and Addrass of Facility 21. Signature of Fuheral Service License SOL LEVINSON & BROS., INC. UL 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximata Intarval Between Onsat and Death 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immedieta Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consaquance of) Examiner hmohil attending physician end for use es the buriel-trensit the death certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Undarlying Causa (Disaasa or injury Dua to (or as a consaguenca of) Box 68760. Physician/Medical that initiated avants rasulting in daath) Last Dua to (or as a consequence of): 23b. Did tobecco use contribute to the cause of deeth? ed by the a Pert II. Other algnificent conditions contributing to death but not resulting in the underlying causa given in Part I. signed by t d be detech 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown that þ of Vital Records. The law requires 24b. Wera autopsy findings evailable prior to completion of cause of death? pinous 24a. Was an autopsy Completed peen s pege 2 this certificate hes 1 Yas 1 ☐ Yas 2 ☐ No Physician: 25. Was casa rafarrad to medical axaminer? 26. Placa of Death (Check only ona) Be Hospital: 1 √Inpatiant 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yes 2 No 70 in 24 hours effer death.
in 24 hours effer death.
the Funeral Director: Affer thi 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Divatural 1 Yas 2 No 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicide to Certifying Physicien: To the best of my knowledge, deeth occurred at tha tima, data and place, end due to the causa(s) and menner es steted.

2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29e. Certifier Medical сотрівтер (Check only one) To the To the To the 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifiar 29c. Licansa number 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) 31. Data filed (Month, Day, Year) SEP 0 3 1998 Rendellston State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 2 5 9 0 9

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				Wood	dlawn				9/4/98	Woodlaw	n, Md.	
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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year **Physician** GREY 31, 1998 4c. County of Death 6:45 A.M RUS HARRISON AUGUST /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner LOLORA ROAD H Under 24 Hrs. 8. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1X M 2□ F 346 36 4695 Usual Residence of Decedent Yrs. Director JEE 76. 22 MORTHLAROLINA 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits mass or 28a-f show 1 Yas 28 No Director CHANAGO 50 DLORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 875 LOLORA 21917 SOAO S.A Funeral Nome 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after mare of Healith and Mental Hyglens.

Intil filem 27 is marked other than "natural; or the mry or other traumatic event, in a section Enemies by or other traumatic event, in a section Enemies. Armed Forces:

12 Yas 2 No
If Yes, Giva
Yaar or Dates: KoRSA 1 Nevar Married 2 Married 21215-0020 1 Yes 2 No Specify Specify: WHITE þ 3 ☐ Widowed ◆ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry DASTERS Elemantary/Secondary (0-12) College (1-4or 5+) BYRS. DZCAO. 123LNIAIZ Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) 8 HARRISON ckis WORT HILLIARD 0 TA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) COLORA, MARYLAND KOAD GREGORY DALE HARRISON 875 COLORA Baltimore. 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition SEPT. S. 20c. Location - City or Town, Stata Department of H Important: If its any injury or of Burial 2 Cramation 3 Removal from Stata BELAGR 4 ☐ Donation 5 ☐ Othar (Specify) EMORIAL DARDONS 22. Name and Address of Facility
EVANSEVERAL CHAPTI-BELAIR, P.A.
3 NEWPORT DRIVE FOREST HALL MAR 21. Signature of Funeral Service-Lie MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final Recordent Uninary Tract Infections diseasa or condition rasulting in death) Examiner Due to (or as a consequence of): edical Examiner Segore Disorder **Durfal-transit** Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): enebral vaprader Dronder Due to (or as a consequence of): Box **Physician** M The law requires that the deam signed by the Records, P.O. Part tt. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yea 2 PNo 3 Probably 4 Unknown CHF Evillo Cardromagales à 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate of Vital after death.

Director: After this certifications Be 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Othar (Specify) Medical Certification: To 1 Yas 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number of Rural Routa Number, City or Town, State) 6 ☐ Could not be detarmined 3 ☐ Suicide 28e. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 Homicide C 24 hours completely filled Hospital † Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and mannar as stated.

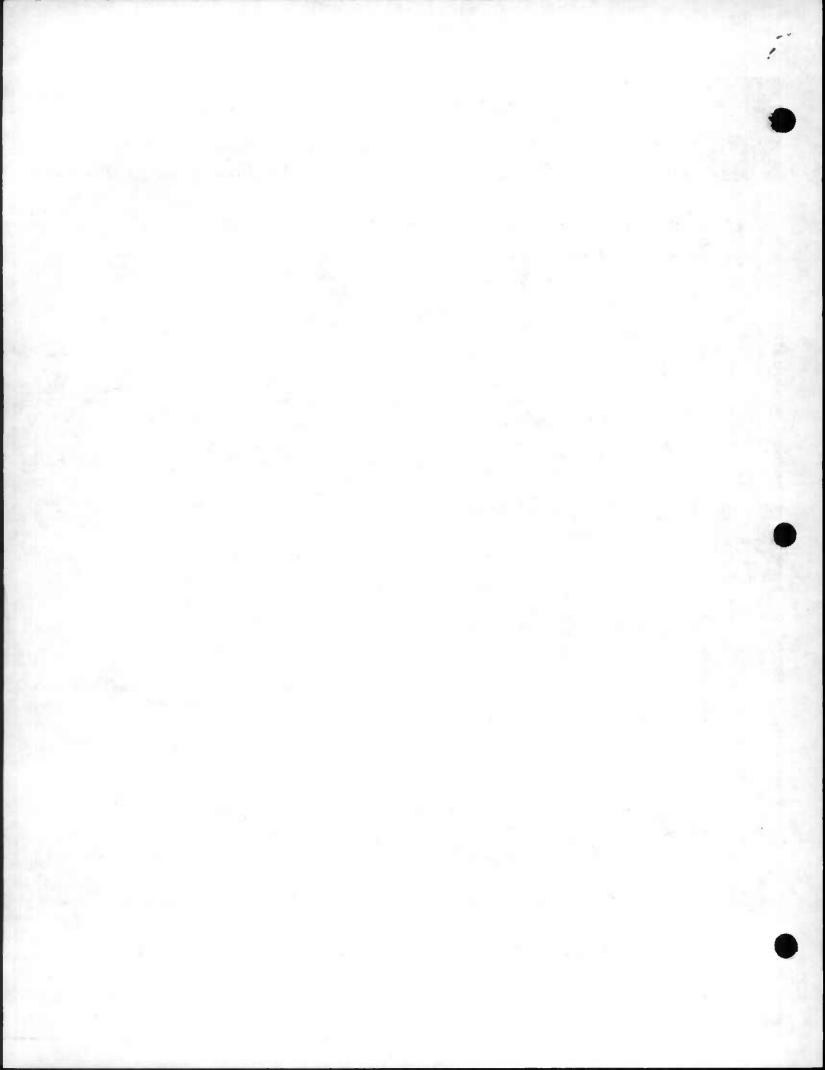
| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signatura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who com causa of death (Item 23a) (Type, Print) COLONIAL WAY Rising Sun Mo. JOSEPH SENDI 101 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State

Registrar

Depersa

SEP 03

1998



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** LAWRENCE BARRETT HOLDRIDGE September 1998 3:45P /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2627 Caves Road Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 88 Director 212-05-9925 March 1, 1910 New York Usual Residence of Decede 10a Stata 10b Counts 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or flame 23a or 28a-f ahor 1 ☐ Yes 2 ₩ No Maryland Baltimore Owings Mills Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 2627 Caves Road 21117 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. a filed within 72 hours effer if Hygiene. other than "natural", or ite 1 Yes 2 No If Yas, Give Year or Dates: 1 Never Married 2) Married 21215-0020 1 Yas X No Specify Specity: White py 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hydraulic Engineer permit. Pages 1 and 2 should be flied a Department of Health and Mental Hygie Important: if Item 27 is marked other the eny Injury or other treumatic event, the page. Hydraulic Sales aitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Gerald Oakleigh Holdridge Genevieve Vaders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Barbara Holdridge Wife 2627 Caves Road Owings Mills Maryland 21117 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 XX remation 3 □ Removal from Stata 20c. Location - City or Town, Stata Data 9/3/98 4 □ Donation 5 □ Other (Specify) Greenmount Cemetery Baltimore, Maryland re of Funeral Service Lig 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical · ACUTE MYOCARDIAL INFANCTION Examiner Examiner APTERTO SCLENOTIC CARDIOVASCULAIR DECEASE 10 years Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 20 years CHRONIC OBSTRUCTIVE PULMONALY Due to (or as a consequence of): Physician/M Box The lew requires that the deal? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown REWAL PADWLS CHILONIC þ PANOXYSMAL ATRIAL FIBRILLATION/FLUTTER 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1□Yes 2KNo 1 Yes 2 No certificate or Attanding Physician: 25. Was case refarred to medical examiner?
1 Yes 2 No funeral director, 8 26. Place of Death (Check only ona) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa Seasidence 6 Othar (Specify) Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Pending investigation Natural after death. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be ne Hospital or Attain 24 hours after der ne Funeral Directo pletely filled in by the 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi adical 29b. Signatu 29c. Licensa number 29d. Data signed (Month, Day, Year) September 2, 1998 30. Nama and address of person who completed cause of death (from 23a) (Type, Print) Suite 200 Lutherville, Maryland 21093 Charles S. Angell 10755 Falls Road 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State SEP 0 3 1998 ooks

**DHMH 16 Rev 6/95** 

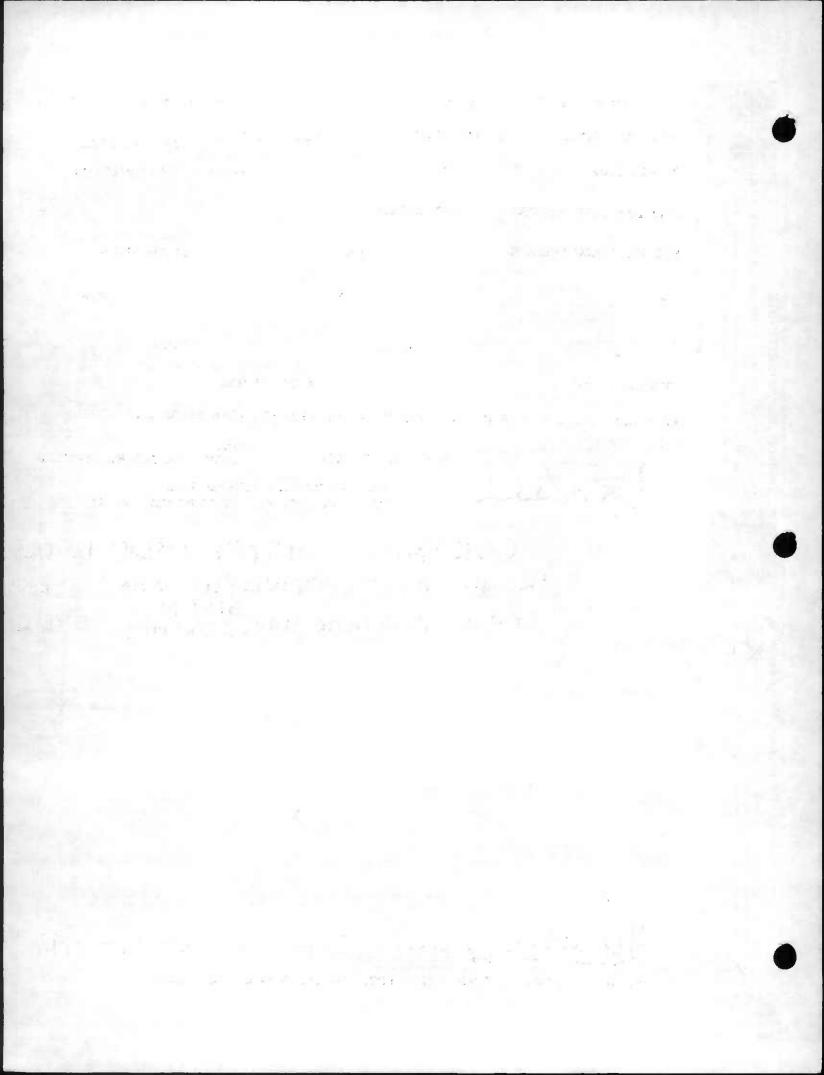
Registrar

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		State of Maryland		artment of artificate of			ene-	6.00	( Co.	
•	1. Decedent's Name (First, Middle, Las	t)				2. Dete of Deat	1		ime of Death	
Physician /Medical	HENRY JOH	N HYMAN					, <sup>D</sup> Y998	Yeer 8:	50 AM	
Examiner	4a Facility Name (If not institution, give		NE		4b. City, Town, or I		4c. County	of Death		
	GENESIS ELDERCARE				BROOKLYN		ANNE ARUNDEL			
Funeral Director	217-24-1202	7. Age (In yrs. In 90	ast birthday Yrs.	Months Days		8. Date of Birth (Month, Day, APRIL 3		9. Birthplece (S Country) MARYLAN	Stete or Foreign	
f show led at	Usual Residence of Decedent  10e. Stete 10b. County  MARYLAND ANNE ARU		Town or L						side City Limits  Yes 2 No	
natural, or items 23a or 28a-f show dical Examiner must be notified at eted by Funeral Director	10e. Street and Number 962 PRINCETON TER	RRACE	37	10f. Zip Code 21061			og. Citizen of V			
"natural", or items 23a or 28a-f show edical Examiner must be notified at letted by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Nover Married 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	S. 13	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spen, Mexican, Puert Specify:	pecify Yes or No- p Rican, etc.)	14. Raca - American Indian, Bleck, White, etc.  Specify: WHITE			
ted tes	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occu	petion	lina .	16b. Kind of Bu	f Business/Industry		
hygiene. her than "natura nt, the Medical E Completed	(Specify only highest grade (0-12) 8	College (1-4or 5+)	DRI		petion a during most of wor ad)		BAKERY	RY		
other ent,	17. Father's Name (First, Middle, Last)			50113	18. Mother's Nan	ne (First, Middle, N	L-31.714			
atic even	CHARLES HYMAN				MARY O'E	O'BRIEN				
or other traum	19a. Informant's Name/Relationship (7 CATHERINE CORBETT	City or Town, RNIE, N	or Town, State, Zip Code) E, MD 21061							
	20a. Method of Disposition  1 🖾 Bugial 2 🗆 Cremation 3 🗀  4 🗆 Dogation 5 🗀 Other (Specify	Removal from State	ametery, cri	osition (Name of ematory or other place) RE CEMETE		SEPT.		City or Town, Si		
Important: any Injury ance.	21. Signature of Europe Service Licen		-	22. Name and Add				, , , , , , , ,		
2 = 3 3	1 Took of	Llil			HWY. S.I			MD 2106	51	
	23a. Part1. Enter the diseese, or comp shock, or heart failure. List only	one cause on each line.	. Do not e	nter the mode of dy	ing, such as cardiac	or respiretory erre	est,	Appr	oximete val Between	
sician edical	Immediate Ceuse (Final	COPO	NIC	LRY	APTI	EDY !	NICE	Onse	t and Death	
miner	disease or condition resulting in death)  a. Due to (or as a presequence of):									
Examiner		RONC	013	STRU	CTIVE	= PVLN	MONA	LKY 13	SYEAR	
redical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	BENIGN	PRO as a conse	Quence of):	c Hyp	ERT	SO PH	1 5	YEAR	
d for u	Part II. Other significant conditions co	antributing to death but not resu	ilting in the	underlying cause o	iven In Part I	23h Did to	hacco use co	ntribute to the s	ause of death?	
been signed by the ettender should be deteched for use leted by Physician/N	rann. Other significant conditions of	withbutting to death but not resu	inting in the	underlying cause g	VOIT IIT CONCI.			3 Probably	Unknown	
sete has been signe page 2 should be d Completed by						24a. Was en	n autopsy ned?	available	on of cause	
s certificate has b lirector, page 2 s o Be Compi						1□ Y€	s 2 No	1 ☐ Yes	2□ No	
ertificel actor, p Be C	25. Wes case referred to medical				26. Place of Dea	th (Check only on	e)			
To B	examiner?	Hospital: 1   Inpatient 2	ER/Outpation	ent 3D DOA	thore . A	ome 5 Reside		er (Specify)		
ereldi	27. Manner of Deeth	28a. Date of Injury	28b. Time Injury	1		28d. Describe ho	-			
al Director: After to led in by the funeral Certification:	1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not be		Yes 2□No	28f. Location (St	reet and Numb	er or Rural Rou	te Number.			
rat bired in bi	4 Homicide determined	building, etc. (Specify	')			City or Towr	, State)			
whith it is hours either this cartificate he completely filled in by the funeral director, page completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Exam	rsfcfan: To the best of my know fner: On the basis of examinat and manner stated.	viedge, dea ion and/or i	th occurred at the nvestigation, in my	ime, dete and plece opinion, death occu	, end due to the ca rred at the time, da	iuse(s) and ma ate and place,	anner es stated. and due to the c	ause(s)	
To the com	29b. Signal that title of certifier 0	neh om	.D.	29c. Licer	1416	0 2	9d. Date signe $09-6$	d (Month, Day,	798	
									1	

State Registrar 31. Date filed (Month, Day, Year) SEP 0 3 1998

\$2. Registrar's Signature



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			C	ertificat	te of	Death		Reg. No.				
Physician	Decedent's Neme (First, Middle,	Albert	John H	enders	son,	Jr.	2. Dete of Dec Month August	Dey	Yaer	3. Time of Death 1:25 AM		
/Medical Examiner	4a Fecility Name (If not institution, g		Iome		1	4b. City, Town, or Dunda			of Deeth	9		
uneral Pirector	5. Social Security Number 216-20-4277	Sax 7. Age	(In yrs. lest birthde	Months	r 1 Yaar Deys	If Under 24 Hrs Hours Min		7. Year) 21, 192	9. Birthpled Country	ce (State or Foreign ) Maryland		
a dan	Usual Residence of Decedent  10a. Stete 10b. County		10c. City, Town or	Location					10d	I. Inside City Limits  1 ☐ Yes 2 No		
5 00	Maryland I	Baltimore				Dunda						
or items 23s or 28s-f show miner must be notified at / Funeral Director	10e. Street end Number 3525 McShane Wa	ay		10f. Zip	p Code 2	21222		10g. Citizen of Whet Country? United States				
2	11. Marital Status  1 □ Naver Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYas 2 N If Yes, Give Yeer or Detes:		3. Was Dace tf Yes, spe		lispenic Orlgin? (S an, Mexican, Puar Specify:	Specify Yes or No to Ricen, etc.)	No- 14. Race - Amarican Indian, Black, White, etc. Specify: White				
traumatic event, tra Magical I	15. Decedent's (Specify only highest Elementery/Secondary (0-12) 12 Years	Education grade completed) College (1-4or 5	(G life		ork done use retire	pation during most of wo d) nspector	rking		Kind of Business/Industry  Electrical			
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reumatic event, tre M	19e. Informent's Neme/Reletionship					end Number or R						
othe	Mrs. Marie R. H 20a. Method of Disposition		20b. Plece of Dis		me of		undalk,	Marylan 20c. Location -				
ŏ	Burial 2 Cremetion 3 Premovel from State 4 Donetion 5 Other (Specify) Sacred Ht. of Jesus Cem. 9/1/1998 Dundalk											
injury B.	21. Senature of Funeral Service Lin	1	Sacred			us Cem.	9/1/1998	Dunga	ik, Ma	ryland		
any injury	1 / / 1	DILL	-	Duda-	Duale	Funoral	Home of	Dundal	k, Inc			
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-	23a. Pert. Enter the disaesa, or so shock, or heert tailure. List or	omplications that caused	the eth. Do not	enter the mo	da of dyir	ng, such es cerdia	c or respiratory e	rrest,	A	pproximete ntervel Between		
ician		,	1						C	Onset end Deeth		
dical	Immediate Cause (Final	DWG	14 000 11=	NO			3	-days .				
iner	disease or condition resulting in death)  Preumon P  Due to (or es e consequence of):									yes.		
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Com							10	Yes 2 No	10	Yes 2 No		
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I director,	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/Outpe		OA		Home 5 Resi	dence 6 □Oth	nar (Specify)			
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atlo	2 ☐ Accident investiga	tion		М		Yes 2 No						
led in by the funera Certification:	3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicide determin	28e. Plece of Inju- building, etc	ry - At home, farm, (Specify)	street, tector	ry, office	-	28t. Location ( City or To	Street and Numb wn, Stete)	ber or Rurel I	Route Number,		
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M M	29b. Signeture end title of certifier	and mainter sta		29	c. Licens	se number		29d. Date signe	ed (Month, De	ey, Year)		
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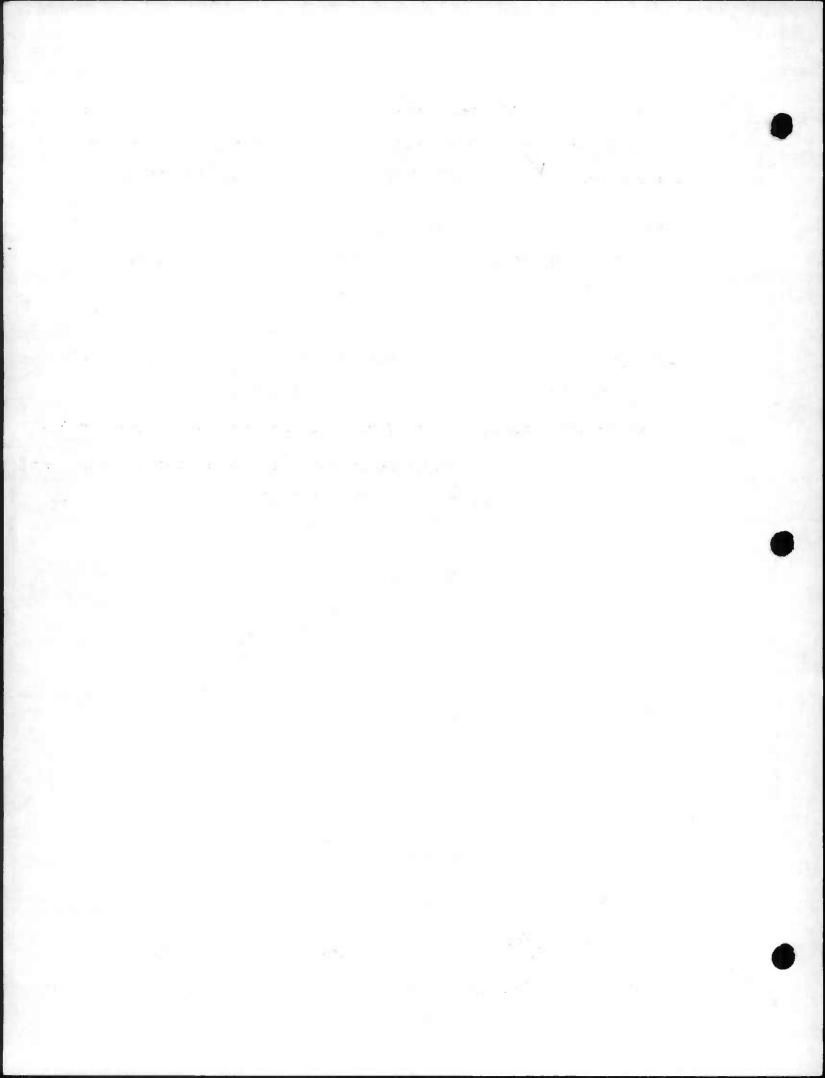
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Examii		4a. Facility Nama (If not Institution, g	ive street end number	r)			4	4b. City, Town, or	Location of Deeth	1 40	c. County	of Death		
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and and		10e. Stata 10b. County		10c. City	, Town or Lo	cation						10	Od. Inside	City Llm
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TEE		Vicki Johnson 20a. Method of Disposition	i-daugnice	20b. Pl	ace of Dispo	sition (Na	ma of		Street,			City or To		
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181	sk Sk	Part II. Other significant conditions	t conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did							tobacc	o use cor	ntribute to	the caus	e of de
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has b	ple											of c	nplation o	i causa
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s certificate director, pag	Be (	25. Was casa rafarred to medical axaminar?						26. Place of De	ath (Check only o	na)				
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ir death. octor: After this certific by the funeral director,		27. Manner of Death 1. ■ Natural 5 □ Panding	28a. Data of fnj (Month, D.	jury lay Year)	28b. Time of Injury	2	8c. injun	y at k?	28d. Dascribe I	now inju	ury occurr	red		
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within 24 hours after deatl To the Funeral Director: completely filled in by the	29a. Cartiflar (Check only one)  29a. Cartiflar (Check only one)  20 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and control of the causa(s) and co							s) and ma nd place, a	innar as stand due to	ated. tha ceus	a(s)			
within To the comple	Me	29b, Signature and taler of eartifier	///			290	c. Licens	e number	T	29d. D	ete signer	d (Month, L	Dey, Year	)
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		21 Date filed March 2	MITLES	E		THER	DU	1 ct	1111174m	<b>D</b>	MED	FLAC	>1	210
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Registr	ar	JLT U i) II	JJO I POS	The same of the sa	/7	A.		<i>*</i> .						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Veer DALE E. JOHNSON 8 29 98 10:46PM 4e. Fecility Neme (If not institution, give street end number)
NATIONAL NAVAL MEDICAL CENTER 4b. City, Town, or Location of Deeth 4c. County of Deeth BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) Sept 27 1946 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Days Hours 1 M 2 XF 51 026-34-6588 Yrs. Mass. Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Fairfax Lorton 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 8811 Sylvania Street 22079-1612 USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give A WHITE 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedant's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Homemaker At Home 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Herbert P Heathcote Edith A Moore 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Philip J Johnson/Spouse 8811 Sylvania St. Lorton, VA 22079-1612 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burial 2 Cremetion 3 Removel from State 9/4/98 Arlington National 4 ☐ Donetion 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilura. List only one cause on sech lina. Approximate Intervel Between Onsat and Death CHOLANGIOCARCINOMA Due to (or es e consequence of): UPPER GASTROINTESTINAL BLEEDING Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of daath? 24e. Wes en eutopsy performed? ZO No 1 ☐ Yes 2 ☐ No 26. Placa of Death (Check only one)

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Director

Funeral

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Completed

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death with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manylan Depertment of Health end Mental Hyglone. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, I'm Medical Exertine man to nother traumatic event, I'm Medical Exertine man to nother traumatic event, I'm Medical Exertine man to nother traumatic event, I'm Medical Exertine man to not a man to man

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O.

completely filled in To the Hospital o within 24 hours of To the Funeral Di Registrar

Immedieta Ceuse (Final diseese or condition rasulting in deeth) Sequentially list conditions, if eny, laading to immediate causa. Enter Underlying Ceuse (Disaase or Injury thet initiated events resulting in deeth) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Wes case rafarred to medical exeminar? Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 27. Manner of Deeth 1 DNaturel 28a. Data of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicida 29a. Certifier (Check only one) 1 Certifying Physicien: To tha best of my knowledge, deeth occurred et the time, data end place, end dua to tha causa(s) end mannar es stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and mennar stated. 29b. Signatura of pertition 29c. License number 29d. Dete signed (Month, Dey, Yeer) D.C. MO 30545 AUGUST 30,1998

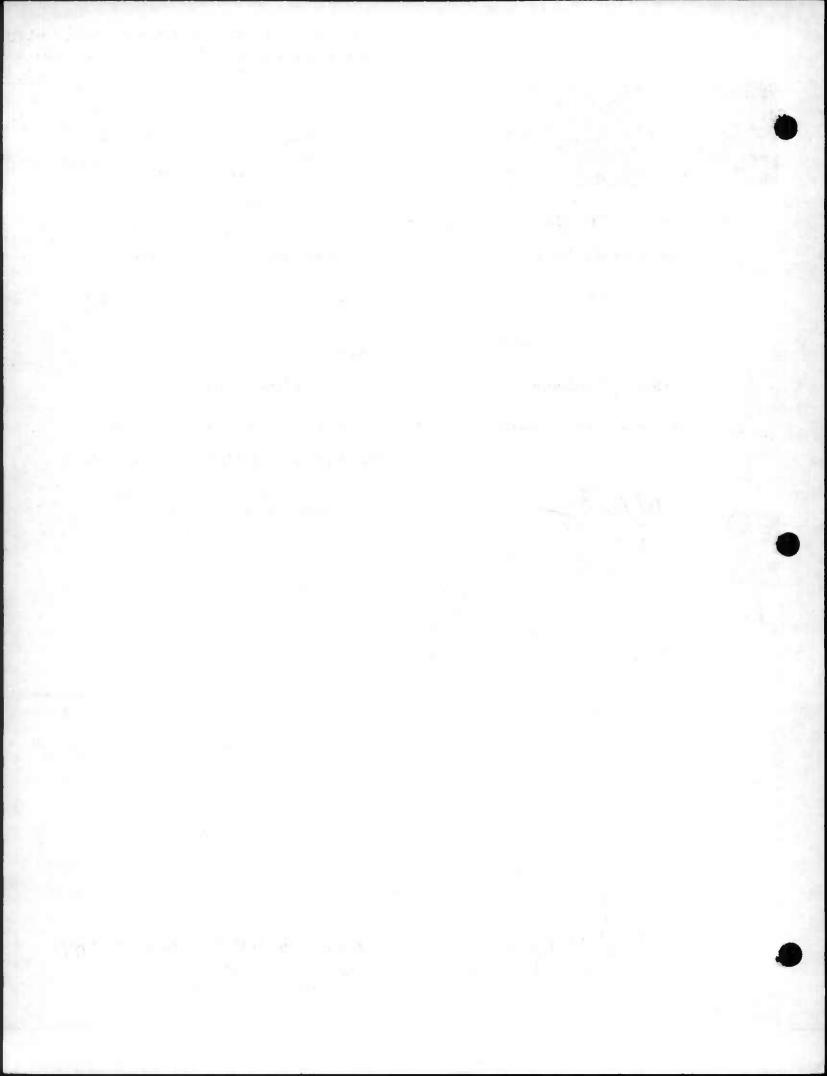
31. Dete filad (Month, Day, Year) SEP 03

RAYMOND PUMAREJO

32. Registrar's Signeture

BETHESDA, MD 20889-5600

COR PAIGE Of Seath (Itam 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER



Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#31 per DVR G763 9/3/98 EW 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death IVIan 0:00 AM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RANKLIN BACTIMIRES 5// 51. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days 1 M 2 F Months Hours 217-18-5530 12/3/1920 Maryland **Usual Residence of Decedent** 10b. County 10c. City Town or Location 10d. Inside City Limits N/A Baltimore 1√2 Yas 2 No 10f. Zip Code 21201 124 W. Franklin Street 10g. Citizen of What Country? U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Detes: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bleck, Whita, atc. 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Unknown 17. Fether's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Clarence Kelly Mary Ellen Younger 19a. Informant's Name/Reletionship (Type, Print) Barbera Hamilton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 W. Franklin Street Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Buriat 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore/Washington Crem. 8/29/98 Laurel, Maryland
22. Nama and Addrass of Facility Dippel Funeral home Inc. 21. Signature of Funeral Service Licensee 8 7110 Belair Road, Baltimore, Maryland 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediete Causa (Final disease or condition rasulting in death) cerebrel V as auda aca Due to (or as a consequence of): Candurascula us o clarelia Dua to (or as a consequence of): Hypert suggest Descore Due to (or as a consequence of):

**Physician** /Medical Examiner

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10a. State

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r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be flied within 72 hours after death 1 Department of Health and Meniel Hygiene. Important: If Item 27 is marked other than "natural", or Herns 23a and Injury or other traumatic event, the Medical Experience 2009.

Baitimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

the Maryland

With

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last þ

Part II. Other significant conditions	contributing to death but not re	sulting in the underlyin	g cause given in Pa	rt I.	23b. Did tobacco use co	ntribute to the cause of death?  3 Probably 4 Unknown
					24a. Was an autopsy performed?	24b. Wera eutopsy findings evailable prior to completion of causa of death?
					1 Yas 25 No	1 Yas 2 No
25. Was case referred to medical			26. Pla	ce of Deeth (	Check only one)	
axaminer?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4	Nursing Home	a 5 Residence 6 Oth	nar (Specify)
27. Manner of Death  1 O Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. tnjury at Work? 1 Yas 2	□ No	d. Describe how injury occur	red
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	nysician: To the best of my kn miner: On the basis of axamin and manner stated.					

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; it Medical Certification: To Be State

assows

29c. License number D 10134 29d. Data signed (Month, Day, Year) aug 26, 1958

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

721228 RITCHIO Hen

31. Data filed (Month, Day, Year) SEP 0 3 1998 Registrar

29b. Signature and title of certifier

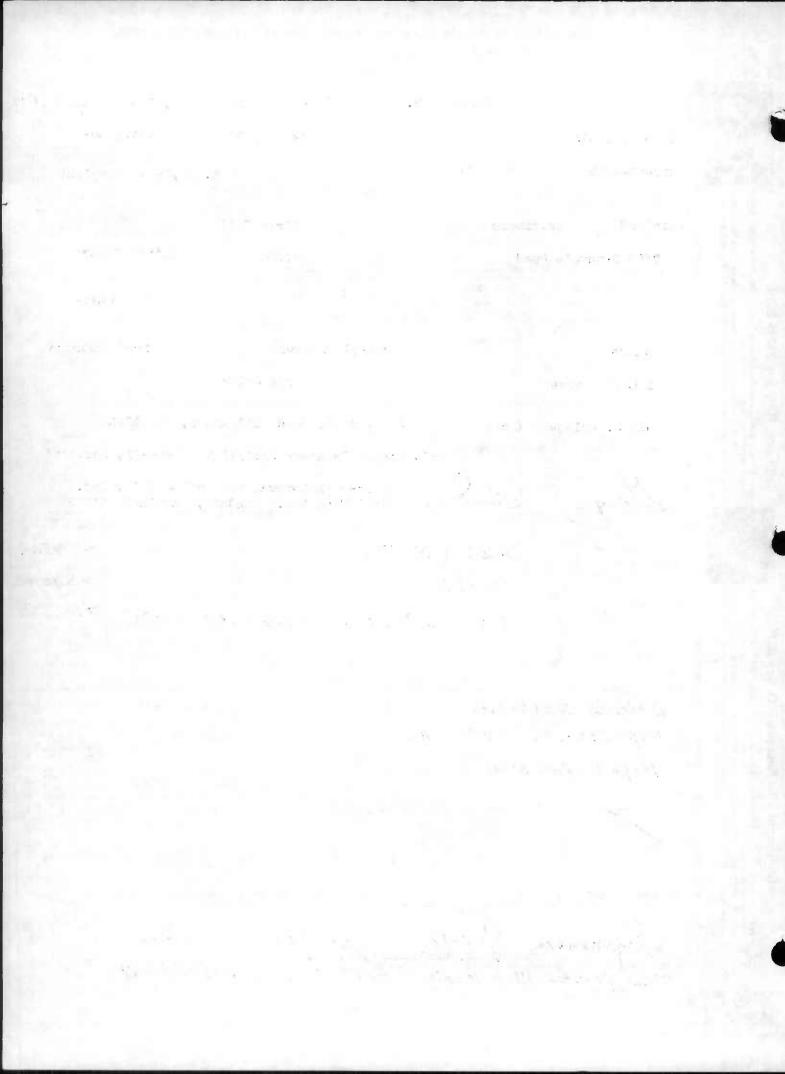
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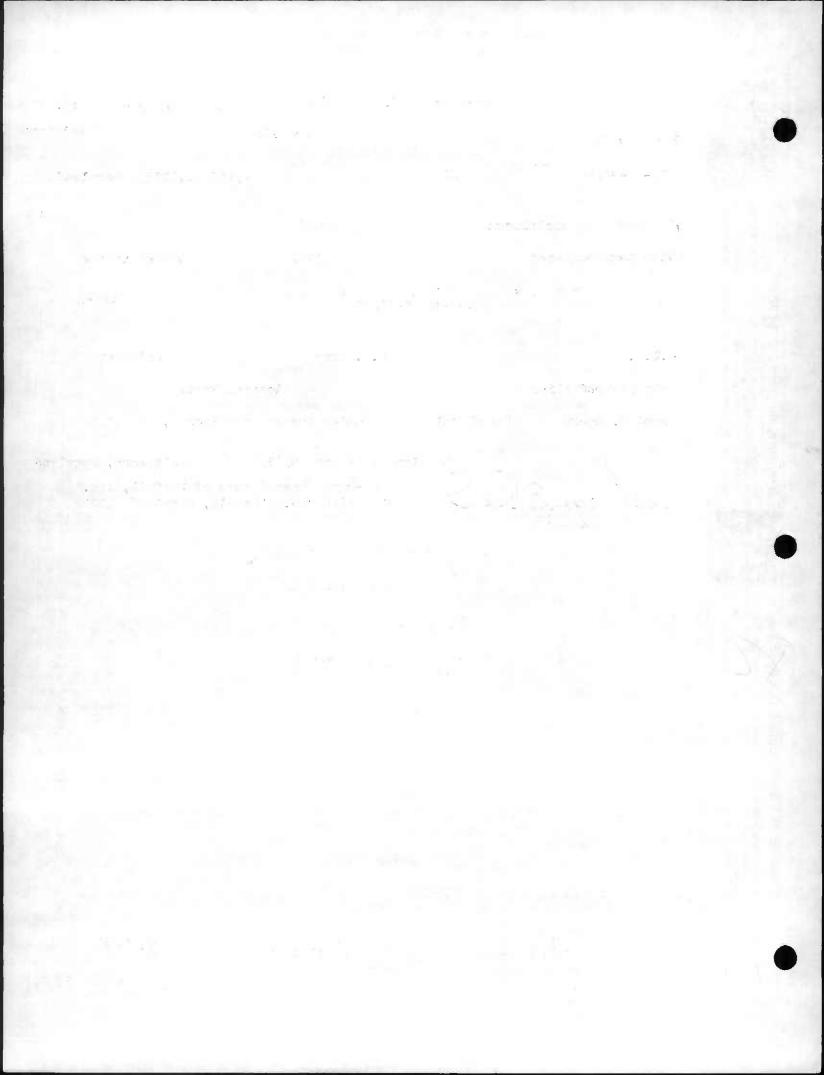
State of Maryland	Department o	f Health and Menta	Hygiene

				Ce	rtifica	te of	Death			Reg. No.		
Physician /Medical	Decedent's Name (First, Mid	dle, Last)	Marie	s.		Kul	aga			27, 199	Yeer 8	3. Time of Deeth 4:35 P. P
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neral ector	5. Social Security Number 218-07-4933	6. Sex 1 ☐ M 2区	7. Age (In yrs. 83	last birthday) Yrs.	If Unde Months	Days		24 Hrs. Min.	8. Date of Bir (Month, De	th by, Year) 29,1914		elaca (State or Foreign etry) yland
anow Market	Usuei Residenca of Decedent  10a. Stete 10b. Coun	ty	10c. Cit	y, Town or L	ocation						1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
Director	Maryland 10e. Street end Number	Baltimor	re		10f. Zi	p Code	Pe	rry 1	Hall	10g. Citizen of	Whet Cour	
al Die	9409 Dawnva	le Road					212	36		United	1 Sta	tes
by Funeral	11. Maritel Status  1 Never Merried 2 Ma  3 Widowed 4 Divorce	Armed	Decedent Ever in U d Forces? es 201 No Give or Dates:	,S. 13.	Was Dece If Yes, spe 1 \( \text{Yes} \)				ecify Yes or No Rican, etc.)	14. Rac Ble Specifi	ck, White,	ean Indien, etc. ite
	15. Decede (Specify only high	ent's Education	ed)	16e. Dece	dent's Usu	al Occu	upation e during mos ed)	st of work	ing	16b. Kind of B	usiness/In-	dustry
Completed	Elementery/Secondery (0-12) 8 Years	Colleg	e (1-4or 5+)				ed) aitres			Fo	od I	ndustry
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10	19e. Informent's Name/Reletion			10b Maili	ina Addres	e (Strai	at and Numb	er or Rur	al Boute Numb	er, City or Town,	State 7ir	Code)
important: If the any injury or of once.	20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other 21. Signature of Americal Service  23a. Part Lenter they seaso, shock, or heary acture.	(Specify) e Licansee	om State Ho	2	Sary 2. Name e	Cem	etery	ity	Home oundalk, or respiratory e	f Dunda	lk, M	nc. 1222 Approximate Intervel Between
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I director.	25. Wes case referred to medic exeminer? 1 ☐ Yes 2 ☐ Mo	Hospital:	☐ Inpatient 2☐	ER/Outpetie	ent 3 🗆 🖸	OA C	thor		th (Check only	one) idenca 6 □Oti	ner (Speci	(v)
	27. Menner of Deeth	28e. D	ete of Injury Month, Dey Year)	28b. Time of Injury		28c. In				how injury occu		
pletely filled in by the funera edical Certification:	3 ☐ Suicide 6 ☐ Coul	mined 200. F	lace of Injury - At houlding, etc. (Specif	ome, farm, si	treet, fecto	ry, offic	Э			(Street and Num. iwn, Stete)	ber or Rur	el Route Number,
pletaly filler	29a. Certifier  (Check only one)  29a. Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as (Check only one)  2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due on the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and menner as the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the control of the cause(s) and the cause(s									enner es s end due t	iteted. o the ceuse(s)	
Med	29b. Signature and little of certain	Mm, Teodi	Jones	) Iglinau		DI	(O)	2		29d. Date signe	8/9.	Dey, Year)
6	30. Name end eddress of person			n 23e) (Type	BAL	71	MOR	LE,	ND	2/22	7	
State	31. Date filed (Month, Dey, Yee		2. Redistrer's Signe	eture &	1	pa.	61					



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				(	Certifica:	te of	Death		R	eg. No.		
		1. Decedent's Name (First, Middle, Las	st)					1	2. Date of Deat	h	Vene	3. Time of Death
н	Physician /Medical		Raym	ond	J.	K1:	ine		Month August	Dey 28, 19	Year 98	1:45 PM
	Examiner	An Capita Name of and institution of a					4b. City, Town Dunda		ation of Death	4c. County of		Baltimore
	Funeral Director	5. Social Security Number 6. S 213-09-3588 Usuat Residence of Decedent	TXM 2 F	n yrs. last birth 82	Months	Days		Min.	B. Date of Birth (Month, Day, pril 20			ace (State or Foreign try) yland
	lend Market	10a. State 10b. County	10	c. City, Town	or Location						10	Od. Inside City Limits
	Mary For	Maryland Ba	ltimore			Dane	ndalk					1 ☐ Yes 21 No
	vith the Market secretary	10e. Street and Number	TCIMOTE		10f. Zi	p Code	IUAIN		1	0g. Citizen of W	hat Coun	try?
	th wit	7525 Lawrence Ro	ad			2	1222		100	United	Stat	es
020	72 hours after deeth with the Maryland natural; or items 23s or 28s-f show you like investigate the notified as shad by Finneral Director		12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: KO	TIWIT				n? (Spec Puerto R	ify Yes or No- ican, etc.)		, White,	en Indian, etc.
0-10	"natural", polical Exe		ucation	16a E	Decedent's Usu Give kind of w	el Occu	pation	of working		16b. Kind of But	iness/Inc	lustry
21215-0020	within see.	(Specify only highest gra	College (1-4or 5+)		U.S.	ise retire	d)	or working		Mili	tarv	
	在工书 B G						18. Mother	's Name	(First, Middle, I	Maiden Sumame		
yla	Men Men Men Men Men Men Men Men Men Men	John Raymond Kli	ne				3		ra Krau			
Maryland	2 0 0 0	19a, Informant's Nama/Ralationship (1								, City or Town,		
-	s 1 and f Heelth Item 27 other to	Carol C. Myers  20a. Method of Disposition	(Daughte		7418 Ke		Avenu	e N	ottingh Date	20c. Location - 0	212	
Baltimore,	ent o	1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery	crematory or awn Cem	other pla		1/19			4 - 6	Maryland
Ball	pemit. Pe Departmen Important: any injury pnce.	21. Signature of Fureral Service Licen	200	)_	Duda-	Ruck		al H		Dundalk Maryland		c. 222
		23a. Part1. Enter the disagram or contra shock, or heart failure.	plications that coused the	deeth. Do no								Approximate Interval Between
	Physician /Medical Examiner	Immediate Cause (Final disease or condition rasulting in death)	a Cono	ieshire	hear	+	(ail	me		ŧ.		Onset and Death
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	executed in and fiel-transit	Security list and this	b. A+	to lorge a co	nsequence of)	. 1(0	, rice					
o,	an an riel-tr	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Causa (Disaasa or Injury	Ц	7.0 (0. 40 4 0	1							
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	of by the attender sets of by the attender betached for upon Physician A.	Part tt. Other significant conditions of	ontributing to deeth but n	ot resulting In	the underlying	cause gi	ven in Pert I.		23b. Dld to	bacco usa con	tributa to	the cause of death?
s, P.0	igned by be detected by Phy								1 🗆 Y	es 2 No	3 Prot	bebly 4 Unknown
Record	aw requires to been so a should be should								24e. Was a perform	n autopsy ned?	ev:	ore eutopsy findings ailabte prior to mplation of ceusa death?
H	The la								1 D Y	s alino	1 🗆	Yes 2 No
/ita	cartificate irector, peg							of Death	(Check only or	(a)		
Division of Vital	ald by	1 Yas 2 No	Hospital: 1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outs		28c. Inju		21	100	ence 6 Othe ow injury occurre		()
Division	tal or Attanding P rs efter death. al Director: After t ed in by the funera Certification:	2 Accident investigation 3 Suicide 6 Coutd not be 4 Homicide determined		At home, fam Specify)				2	8f. Location (Si City or Town	reet and Number n, State)	or or Rura	I Route Number,
	To the Hospital or Attano within 24 hours efter deal To the Funeral Director: completaly filled in by the Medical Certifical		ysician: To the best of m liner: On the basis of exa and manner stated	y knowladge, amination end	death occurred for investigation	l at tha t n, in my	ma, data and opinion, daath	place, ar	nd due to the c d at the t me, d	ausa(s) and mai ate end place, a	nner as si	ated. the cause(s)
	outhor vithin complete		aa mamor stated		29	c. Licen	se number		2	9d. Data signed	(Month,	Day, Year)
	- > - 0	1	10-00		1	00	F6 19'	7		818	28/9	1
	10+1	30. Name and address of person who	complated ceuse of death	(Item 23a) (T	ype, Print)	Varl	L Vn	, v(	Malh		lux	2124
	State	31. Date filed (Month, Day, Year)	32. Registrer's		4	100	1,	1	, - 1/1	1		
	Registrar	GED U 3 JC	YX XX	-	N. A.	UCH	21					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 52 Am 4c. County of Death 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Sociel Security Number nond 7. Age (In yrs. last birthday) If Under 8. Data of Birth (Month, Dey, 9. Birthplace (Steta or Foreign 6. Sex 10 M 200 F Months Days Hours Min. 423-10-2419 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYas 2 No nore larvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3406 nason 2/22 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race 11. Marital Stetus American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced American Hrican 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WOOD (daughter) 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Md. 21229 40 to. minia 20a. Method of Disposition
1 ☑ Buriel 2 ☐ Cremetion 20b. Place of Disposition (Neme of cematery, cremetory or other) Dete 20c. Location - City or Town, State 3 Removel from Stete Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Nationa of Funeral Service Licenses 22. Name and Address of Fecility Josep 2222 10 Ave 21216 W. Nor th nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rheert failure. List only ona cause on each line. Approximete Intarvel Betwe Onset and Death Immediete Cause (Finel disease or condition resulting in deeth) Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaese or injury that initieted events rasulting in death) Lest Due to (or es e consequence of) Masenc Due to (or es a consequence of): 81 cm. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 X No 1 Yes 1 ☐ Yas 2 ☐ No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner P.O. Box 68760. The law requires that the death certificate be

Division of Vital Records,

or Attending Physicien:

Hospital

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After this

Physician /Medical

Examiner

10a. Stete

Funeral Director

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Completed

Be

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after deeth vacant of Health end Mentel Hygiene.
Mit: If Heart 27 ie marked other than "naturel; or frems 23a my or other traumatic event, the Medical Examine mainty or other traumatic event, the Medical Examine mainty.

Depertment of Health er Important: if Item 27 le any injury or other trau pnce.

21215-0020

Baltimore, Maryland

Physician/Medical Examiner signed by the at d be detached for by Completed Be Medical Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case raferred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Natural

Accident 5 Pending 1 ☐ Yas 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier

Certifying Physician: To the best of my knowledga, death occurred et the tima, data and place, and dua to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, data end place, and dua to the cause(s) end menner stated.

29b. Signeture end title of certifier

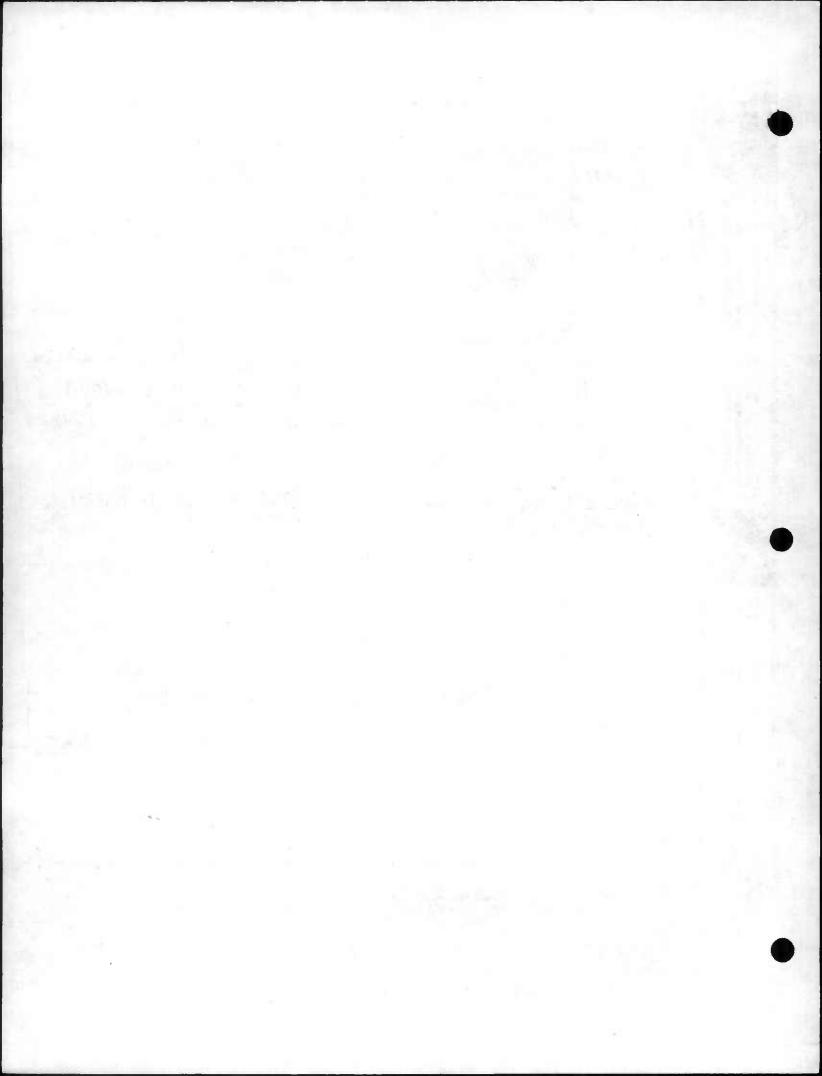
29c. License number 29d. Date signed (Month, Day, Year) 30115

30. Name end eddress of person who completed cause of death (Itam 23a) (Type, Print)

hiokpehai 2600 Liber HUTSIAVE BALLI MOZIZIS Imo

State Registrar 31. Date filed (Month, Dey, Year) 0 3 1998

32. Registrar's Signeture



**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haath and Mental Hygiena. ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumstic event, the Maplical Experient must be notified at

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physicial and completely filled in by the funeral director, page 2 should be detached for usa as the burial cansi

Division of Vital Records, P.O. Box 68760,

Delaski, onda

Baltimore, Maryland 21215-0020

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

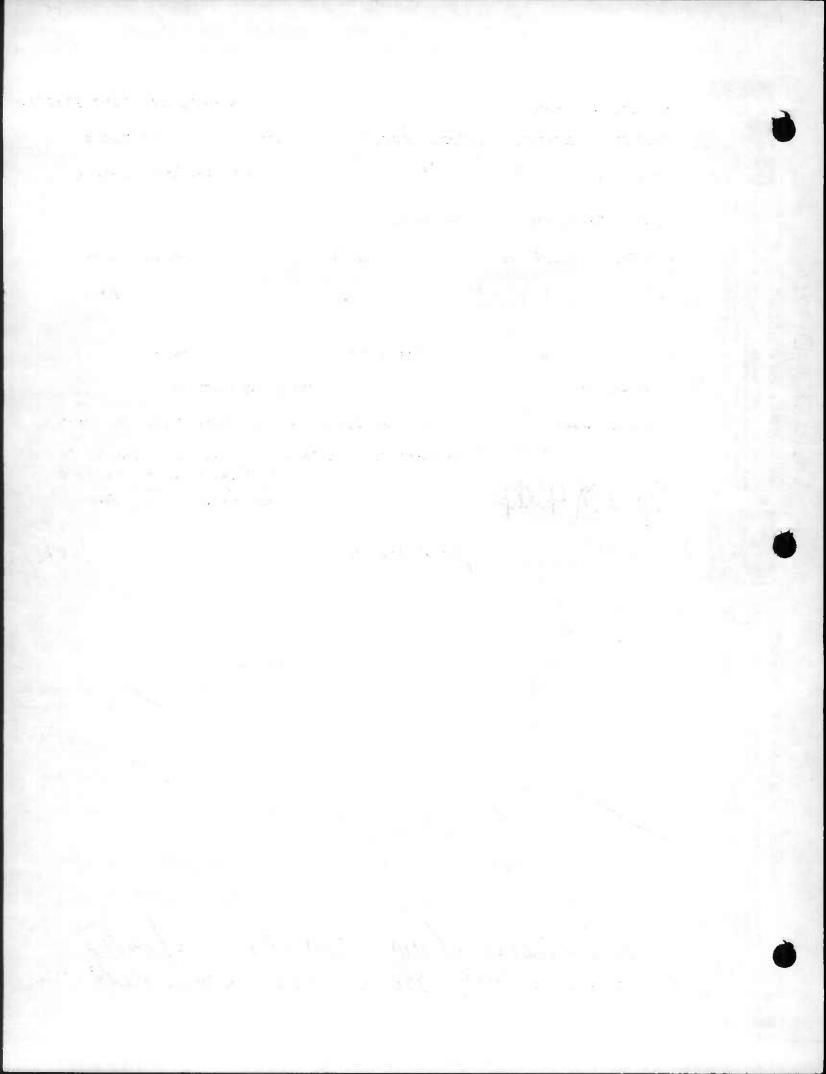
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			Certific	cate of i	Death		Reg	. No.			
1. Decedent's Nama (First, Middle, Last)	)						te of Death		Voar	3. Time of I	Deeth
Onda Odon de Lask	i					A	ÜĞUSI	Day 28,	199	3 11:	15AN
4a Facility Name (If not institution, give	street and numbar)			4	b. City, Town,	, or Location	of Death	4c. Count	y of Death		
GREATER BALTIM	MORE MEL	DICAL	CENTE	R	TOWSO			BAL	TIMOL	RE	
5. Social Security Number  226-84-7859  Usual Residence of Decedent	7. Ag	ge (In yrs. last i 99		Indar 1 Year oths Days	If Under 24 Hours	Min. (Me	ta of Birth onth, Day, Y	'aar) 1899	9. Birthpi Coun Indi	laca (Stata or try) ana	Foreign
10a. State 10b. County		10c. City, To	own or Location	)					10	0d. Inside Cit	y Limits
Maryland Baltimor	e	Owing	s Mills	3						1 🗆 Yes	2 <b>[</b> ] No
10e. Street and Number				f. Zip Code			100	. Citizen of	Whet Coun	try?	
9416 Groffs Mill	Drive			21217			ī	Inited	Stat	es	
	12. Was Decedent	Ever in U,S.		Decedent of H specify Cuba	spanic Origin	? (Specify Ye		14. Ra	ce - Americ	en Indian,	
1 ☐ Naver Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 X If Yes, Give Yaar or Dates:			es 2XINo		ueno Hican,	etc.)		ck, White, by: Whi		
15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted</i> ) College (1-4or		Sa. Decedent's (Give kind of life. DO No	Usual Occup of work done o OT use retired	ation luring most of )	f working	16	6b. Kind of E	usiness/Ind	Justry	
12 4			homemal	ker			ŀ	nome			
17. Father's Nama (First, Middle, Last)					18. Mother's	Name (First,	Middle, Ma	iden Suma	me)		
Oscar Warnock					Jenny	May F	reemye	er			
19a. Informent's Name/Relationship (Ty	rpe, Print)	1	9b. Mailing Ad	dress (Street	and Number o	or Rural Rout	e Number,	City or Town	, State, Zip	Code)	
Donald de Laski			05 Dee		Pond (	Ct., G				22066	
20a. Method of Disposition  1   ↑ Burial 2 □ Cramation 3 □ R  4 □ Donation 5 □ Other (Specify)	lemoval from State	cem e	of Disposition tery, crematory nal Men	or other place norial	Park		98 F	alls	Churc	h, VA	
21. Signature of Funeral Service License	0		22. Nan	ne and Addre	(	Everly 6161 L Falls	eesbu	rg Pik	e		
Immediate Cause (Final disease or condition resulting in death)		Augusto (or as	M/W a consequance	11CL e of):						Onsat and D	K
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	)		a consequence								
resulting in death) Last	1		2 0011004001101						1		
Pert II. Other significant conditions con	tributing to death h	out not resulting	n in the underly	ing cause giv	en in Part I	2	3b. Did tob	acco use c	potribute to	the cause o	f death?
Pat II. Other significant conditions con	mibuling to death b	out not resulting	y in the underly	ying cause giv	on in raici.		1 🗆 Yes	/		bably 4 🗆 l	
						2	4a. Was an perform	autopsy ad?	av	ere autopsy fi ailabla prior to mpletion of co death?	)
							1 ☐ Yes	2/2/No	1[	Yes 2	No
25. Was case referred to medical					26. Plece of	f Death (Che	ck only one	-			
examiner?	lospital:	ent 2 ER/	Outpatient 3	□ DOA Oth	or:	ing Home 5			her (Specif	y)	
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	Jry 28t	o. Time of Injury	28c. Injur Wor		28d. D		v injury occu			
3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At home, tc. (Specify)	farm, street, f	actory, office			cation (Stre ty or Town,		ber or Rura	I Route Num	ber,
29a. Certifier  (Check only  2 ☐ Medical Examir		f exeminetion									
one)		7		29c Licens	e number		29	d. Date sign	ed (Month)	Day, Year)	
29b. Signature and title of gentifier	1/11/11	1/1	110	7	771	97	,	4/2	9/0	D	
one)	un pleted cause of c	death (Item 23)	(Type, Print)	Di	111	03	1	H2	9/9	7211	10

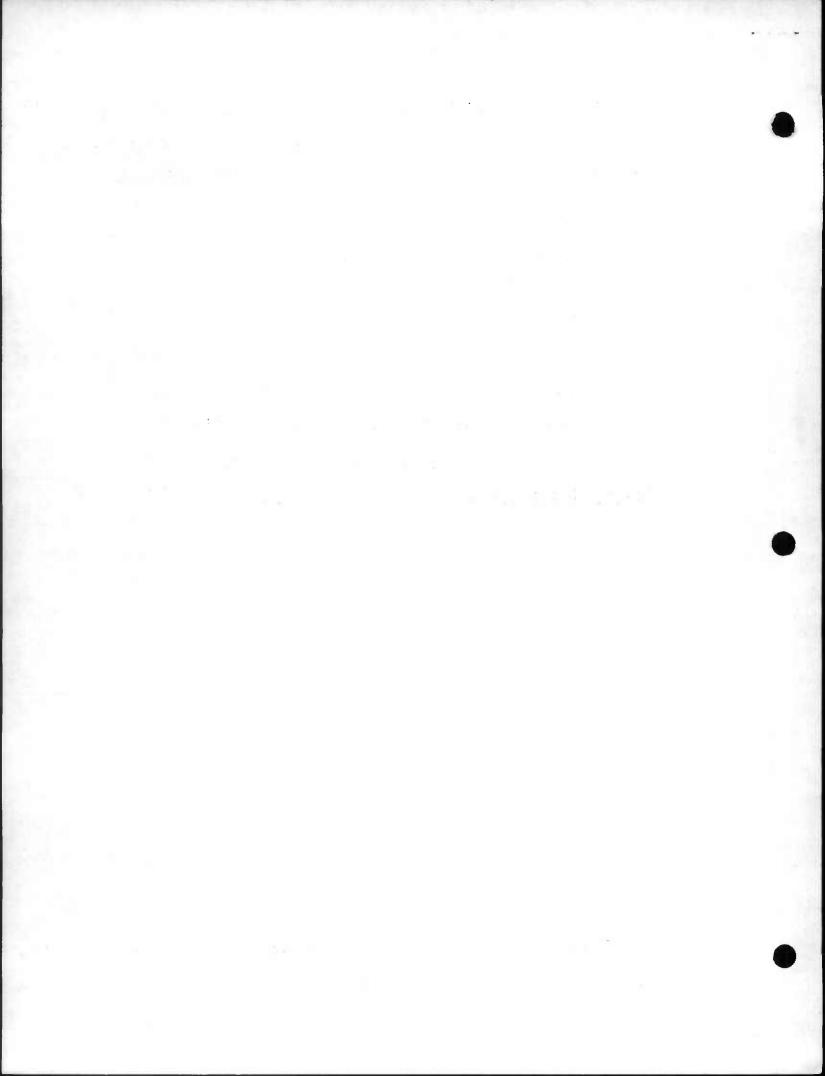
State Registrar

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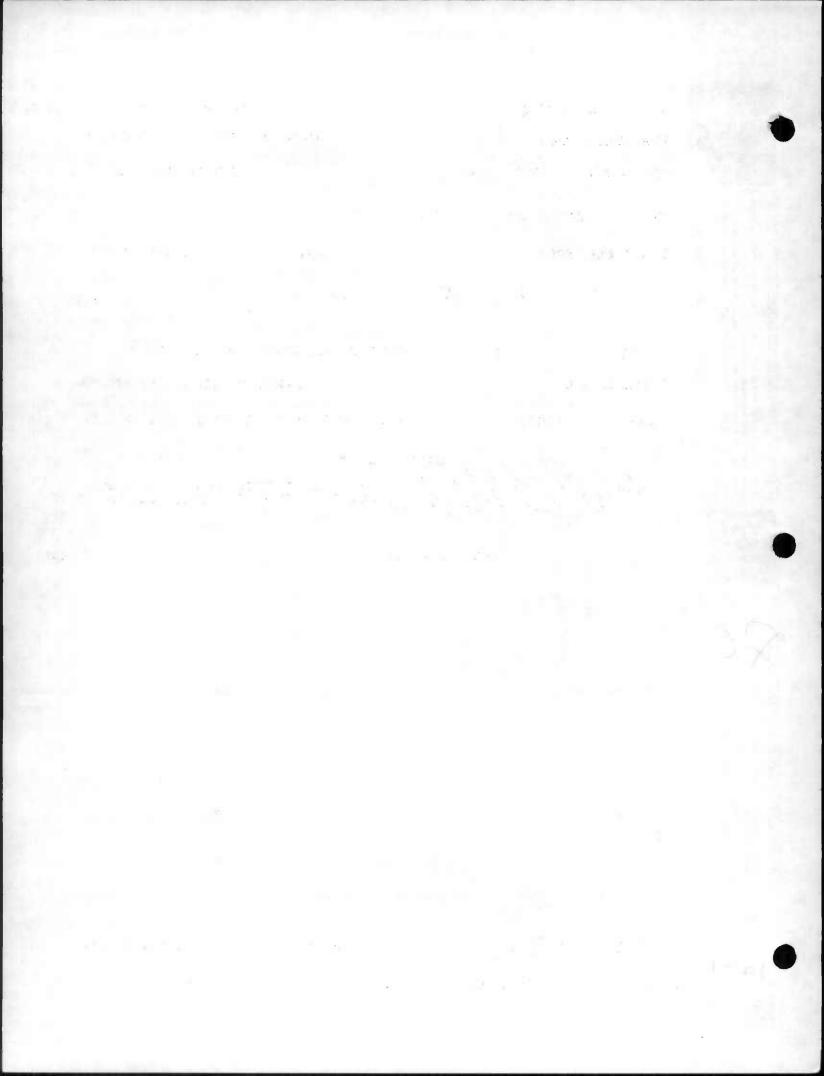


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		Future	ecare						Arno				e Ar	unde	21
Funeral		5. Social Security 1		Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs	. last birthday	Months 1	1 Year Deys	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	lace (Ste	te or Foreig
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r 28a-f show notified at	Director	10e. Street end Nu	mber			-	10f. Zip (	Code				10g. Citizen of	What Cour	tn/2	
23a or	ō			20				1401				US			
na 23	Funeral	1043 Oak	Tree Lar	12. Was Decede	ent Ever in U	J.S. 13.			spenic Orio	in? (Spe	city Yes or No		ca - Americ	an Indien	
	5		ried 2 Merried	Armed Force 1 ☐ Yes 2	es?	, ,	If Yes, speci	ify Cuber	n, Mexican,	Puerto	ecity Yes or No Rican, etc.)	Ble	eck, White,	etc.	
70.00	þ	3 Widowed		If Yes, Give Yeer or Dete			1□ Yes 2	ON X	Specify:			Speci	ify: W	hite	
natural.	P P		15. Decedent's E	ducation		16e. Dece	dent's Usuel	Occupe	tion			16b. Kind of E	Business/In	dustry	
- 34	Completed	(Special Elementary/Second	cify only highest gra	ede completed) College (1-4	or 5+)	life.	Not work	k done d e <i>retired)</i>	unng most	of worki	n <i>g</i>				
Hygiene. other than	5	8	, ,			Machi	ne Ope	erate	or			Schaef	fer B	rewe	су
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n 27		Kathleen	M. Potts	<ul> <li>daught</li> </ul>	and the second					Ann	apolis	, MD 2	1401		
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int: i			5 Other (Special			klawn	Cemete	erv		9	/2/98	Baltim	ore		
Department Important: i any injury o once.		21. Signeture of Fi	unerei Servica Lica	nsee		2	2. Neme end	Addres	s of Fecility	,			11.		
SESS		X	- OH	Will	Lan							atonsvi atonsvi			21228
		23a. Pert1. Enter	the diseese, or comert feilure. List only	plications thet cau	sed the dee	th. Do not en	iter the mode	of dying	, such es d	ardiec o	or respiratory e	rrest,	110,		nete Between
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ledicai		tmmediate Cause diseese or condition		ART	ERIC	SCIB	ROT	10	CA	RD	LOVAS	CULA	C .	2 YE	ARS
aminer		resulting in death)		ā							-	-			
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traum traum	19a. Informant's Name/Ralationship IRENE H. LEIBIO		19b.	Mailing Address (							AND 20904
or other	20a. Mathod of Disposition 1 🖾 Burial 2 🔾 Cramation 3	☐Ramoval from Sta	an made a	Disposition (Nama y, cramatory or oth	of ar plac	ca)	0/3	Data 3/98	20c. Location -		
deno cian dical iner	21. Signature of Funeral Service Lie 23a. Fight. Enter the disease, or concock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that cau y ona causa on aac	DSTATE CAN	of antar tha moda	RIN	NALDI E AVEN	FUNER UE, S	SILVER	ME, 1180 SPRING, rast,		20904 Approximate Interval Batween Onset and Death 5 YEARS
uso (a material transl sn/Medical Exami	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Dua to (or as a c								
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+1	30. Nama and addrass of person who WILLIAM L. DAHUT	r, 3800 RI	ESERVOIR I		WAS	HINGT	ON, I	OC 2000	)4		
State	31. Data filad (Month, Day, Year)	32. Reg	istrar's Signatura								

Registrar



State of Maryland / Department of Health and Mental Hygiene.

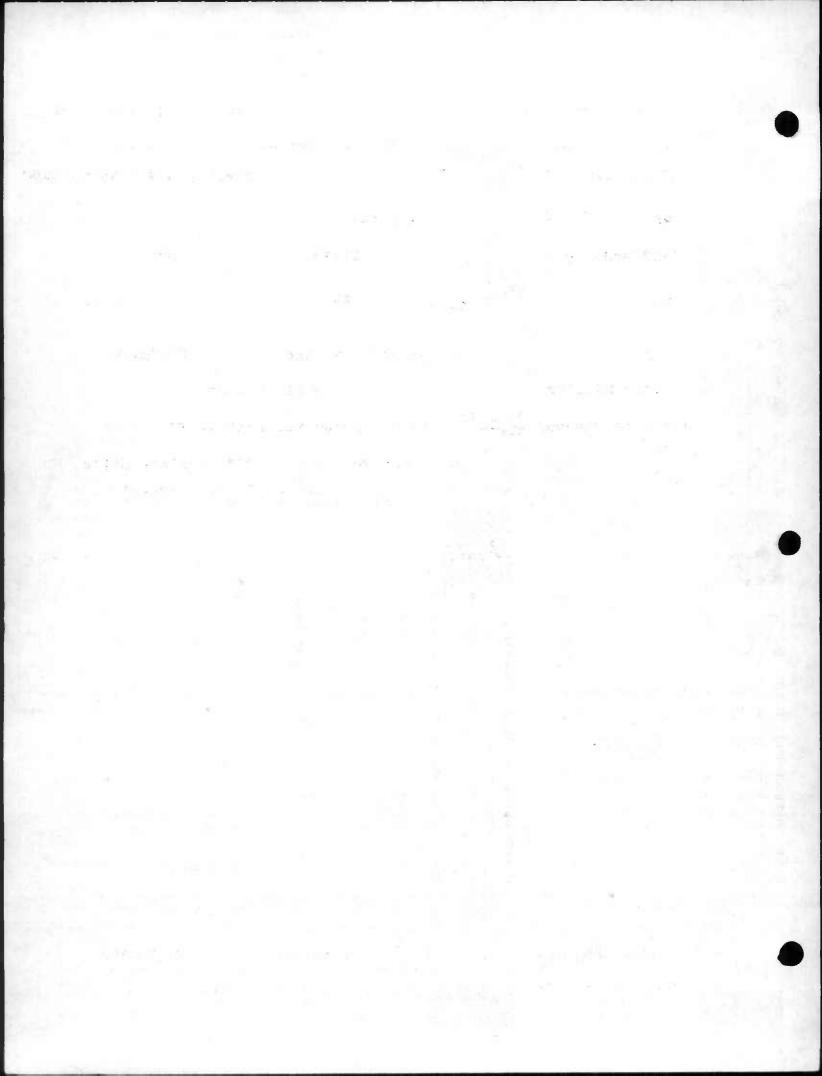
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month 5:56 am JOHN MIMMICK AUGUST 1998 27 /Medicai 4e. Fecility Neme (If not Institution, give street end number) 4b. Cltv. Town, or Location of Deeth 4c. County of Deeth **Examiner** Affairs - Raltimore Baltimore

(In yrs. last birthday)

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
(Month, Dey, Year) Vepartment Veterans Baltimore 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 128 M 2□ F 217-22-9486 Yrs. Director 70 Nov.26,1927 WashingtonDC Usual Residence of Dacedent permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene.
Important if Item 27 is marked other than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and minger than "natural" and "nat 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MYes 2□ No Director MD n/a **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1328 McHenry St. 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ★ Ses 2 □ No If Yas, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 To Specify: by 3 Widowed 4 ☐ Divorced Specify: White Year or Detes: 48-52 Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a Merchant Marine Maritime 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Minnick Nealy Hurmen 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) details Jeanette Cannon/ 10 N. Greene St. Balto., MD 21201 clerk 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete urial 2 Cremation 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest Va 9/4 Owings Mills, MD Signalure of Funeral Service Licenseu 22. Neme end Address of Facility James A. Morton & Sons Funeral Home ames 1701 Laurens St. Balto., MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or haart feilure. List only one cause on each line. Approximete Intervel Between **Physician** Onset end Deeth Immediate Ceuse (Final diseese or condition resulting in death) /Medical 13 days lultiorgan Failure **Examiner** Dua to (or es e consequence of). Examiner Ventricular Aneurysm Sequentially list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated avants resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Infaction Myocardial Physician/Medical Due to (or es e consequence of): The lew requires that the death on Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sepsis, REHAL FAILURE, Endocarditis, Autic Stensis, þ Completed 24b. Were eutopsy findings evellable prior to 24e. Wes en eutopsy Mitral Regregitation complation of ceuse of deeth? 1 XYes 2 □ No 1 ■ Yes 2 □ No or Attanding Physicien: Be 25. Wes cese referred to medice! 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 1■ Inpatienf 2 ER/Outpetient 3 DOA this 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Aftar t To the Hospital or within 24 hours after death.

To the Funeral Director: After the Funeral Miled in by the fur 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Streat end Number or Rurel Route Number, City or Town, Stete) 4 Homleida 1 Certifying Physicien: To the best of my knowledge, daath occurred et tha time, dete end plece, end dua to the ceuse(s) end menner es stetad.

2 Medical Examiner: On tha basis of examination end/or invastigation, in my opinion, daath occurred et tha tima, data and place, end due to tha cause(s) and menner stated. Medical (Check only 29b. Signature end titla of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Nema end eddrass of person who complated cause of deeth (Itam 23a) (Type, Print) 13-10541 8/27/1998 Department of Veteran's affairs, Baltimore MD SETTY 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar SEP 0 3 1998

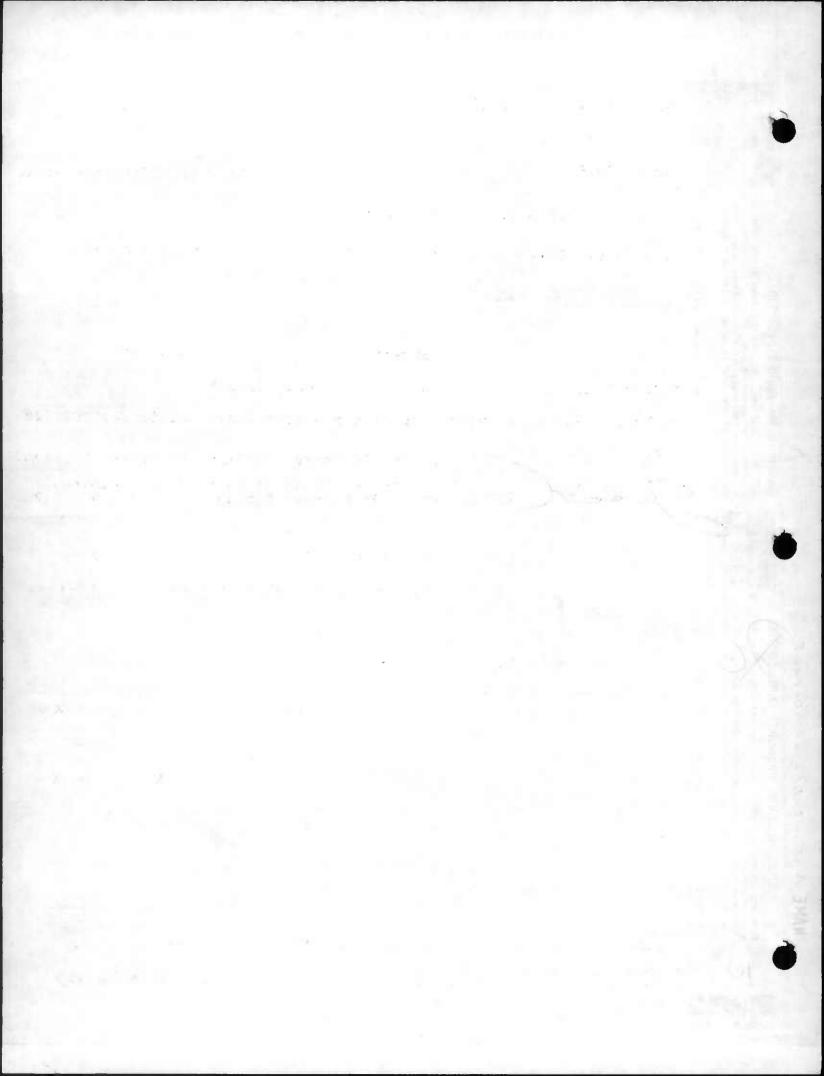


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 6 9 2 4

	1. Decedent's Name (First, Middle,	Last)				2. Data of Dea		Vaar	3. Tima of Death
/sician	Margaret K. M	aszczycki				Month AUg	28 /	Year 1998	13 50
ledical aminer	4a Facility Name (If not institution,				4b. City, Town, or L		4c. County of		
	ST AGNES	Health car	se .		Baltimor	e MD	N/A		
ral tor	5. Social Security Numbar 212-22-5846	1	rs. last birthda Yrs.	y) If Undar 1 Year Months Days		(Month Day	, Yaar) , 1920	9. Birthple Count Penn	aca (State or Forei ry) Sylvani
	Usual Residence of Decedent	100	City Town or	Location				140	d. Inside City Limi
Director	Maryland Bal	timore	City, Town or Balti					10	1 🗆 Yes 2 🖰 N
- ire	10e. Street and Number			10f. Zip Code			10g. Citizen of W		-
rai	1044 Circle D	rive		212			Inited		
by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 Mo if Yes, Give Year or Dates:	1 U,S. 13	I. Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 X No	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race Black Specify:	- America k, White, e	tc.
	15. Decedant's	Education	16a. Dec	edent's Usual Occu	ipation	kina	16b. Kind of But	siness/Ind	ustry
nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	during most of worked)	(III)			
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Be	17. Fathar's Nama (First, Middla, La				18. Mother's Nan		Malden Sumeme	e)	
2	Andrew Krayze				Mary Fa				
	19a. Informant's Name/Relationship Michele Pfann	1 /1 /	618	Cinnamo	n Tree	<i>rai Houte Numbe</i> Court E	Baltimo	stete, zip	MD2122
	20a. Method of Disposition		Place of Dis	position (Name of	-	Date	20c. Location - 6		
	1 ⊠Burial 2 □ Cramation 3	Ramoval from State	cemetery, ci	rematory or other pla					Maryla
	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie			vn Cemet	-			I WII ,	Mar y rai
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15	23d. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused the dealy one ceuse on each line.	eath. Do not e	entar tha mode of dy	ring, such as cardiac	or respiratory ar	rest,		Approximate Intarval Between
									Onset and Death
	Immediate Cause (Final								
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DHMH 16 Rav 6/95

NAME MASZCZYŁKI , MARGMET



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ \} Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Physician SEPTEMBER 014000 00 /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALLST If Under 24 Hrs. GENZRAL HOSPITAL ARFORD STON 700 If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthdey) **Funeral** Months Days Hours 1 □ M 202 F 73 PEDDAYLYANIA Vrs OCT. 23 1924 Director 216 207448 Usual Rasidanca of Decedant 10b County 10c. City, Town or Location 10d. Inside City Limits show r than "naturel", or itema 23a or 28a-f show the Wedical Examiner must be notified at 1 □ Yas 250 No Director BEL RIR PARYLAN HARFORD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code .S.A 12. Was Decedent Ever in U,S.
Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 203 GOOGUATI 14. Race - American Indien, Black, Whita, atc. 11. Merital Status 1 Never Merried 2 Married 1 ☐ Yas 2 No 21215-0020 1 ☐ Yas 2 ☑ No Specify: by TIHW 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiane. Elementary/Secondary (0-12) Collega (1-4or 5+) 12YRS HOMEMAKER Baltimore, Maryland 18. Mother's Nama (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be tile Department of Haalth and Mental Hy Important: If Nem 27 is marked ofth any injury or other traumatic event page. 17. Fathar's Nama (First, Middle, Last) Be Kocco D. LARO IARIA RUGIERI 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 21014 Bal ATR MARYLAND
Data 20c. Location - City or Town, State 502 Linwood Avs JOHN 125128 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Mathod of Disposition SERT. 1. 1 Burial 2 Cramation 3 Ramoval from Stete EVANS 4 ☐ Donation 5 ☐ Othar (Specify) 1998 FOREST HILL 22. Name and Address of Facility
EVANS FUNERAL WHAPEL - BELAIR
3 NEWPORT DRIVE FOREST HILL nature of Funeral Service License PRYLAW NOUS 23a. Pert1. Enter the disease, or complications that ball sed the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on high line. Approximate Intarval Between Onset and Death **Physician** /Medical Immedieta Causa (Final UROSEPSIS disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): 4 YEARS PULMONARY CARCINOMA Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequance of): Due to (or es e consequance of): Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 □ Probably 4 □ Unknown OBSTRUCTIVE PULLWONARY DISEASE Records, 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 100 1 Yas 2 No Be 25. Was cesa refarred to medical axaminar? 28. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Boatural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accidant if or Attend after deat Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital M hours a 12 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated. 29a. Cartifiar Medical 29c. License number
Do Sog 6 29b. Signeture end titla of certifiar 29d. Data signed (Month, Dey, Year) Andew Nowdernla in SEPTEMBER 1,1998

DHMH 16 Rev 6/95

Registrar

125 N. MATA ST. BERALK, MDLONG

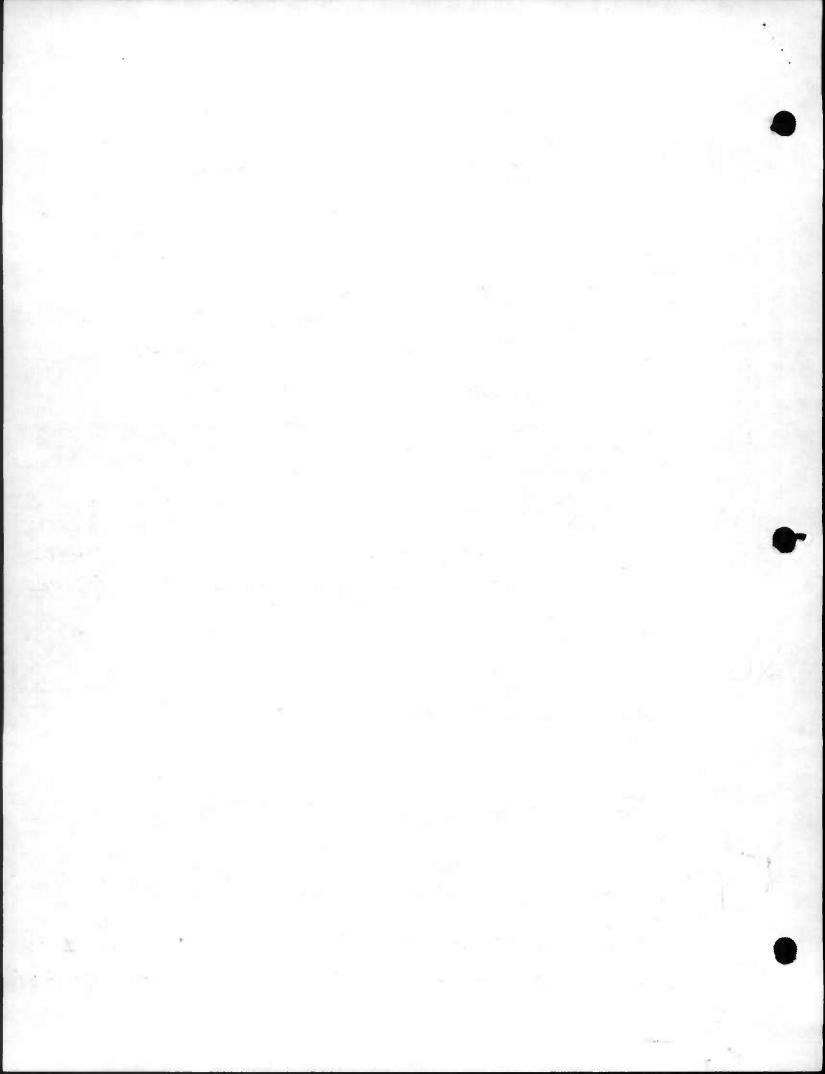
30. Nama and address of person who complated ceusa of death (Item 23a) (Type, Print)

32. Registrar's Signatura

MNDROW NOWAKOWSKI

31. Deta filed (Month, Day, Year)

SEP 03



	State of Ma	aryland /		ment of ficate of		Mental Hyg	iene 🚅 🖔 19. No.	2	5926
1. Decedant's Name (First, Middla, Li	ast)					2. Data of Deat Month	h Day	Yeer	3. Tima of Death
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le. Facility Neme (If not institution, gi	ve street and number)					Location of Deeth	4c. County		
Ridgeway Manor  5. Social Security Number 6.	Sex 7. Age	e (In yrs. last b	hirthday) II	f Undar 1 Year	Baltim	S. 8 Date of Righ	1	altim	lace (State or Foraign
	1□ M 2 X X 8			fonths Days			, 1910	Coun	orado
10a. Stete 10b. County		10c. City, To	wn or Locati	ion				1	0d. Insida City Limits
Maryland Baltin	nore	Caton	sville						1 Yas 3 No
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1 Maritel Status  1 Never Married 2 Married  3 XXVidowed 4 Divorced	Armed Forces?  1  Yas 2 XX  If Yes, Giva  Yaar or Datas:	lo		es, specify Cul		Specify Yas or No- rto Rican, etc.)		ck, Whita,	
15. Decedant's E	iducation	18	e. Decedent	t's Usuai Occu	pation during most of we	ockina	16b. Kind of Bu	usinass/ind	dustry
Elemantary/Secondary (0-12)	Collega (1-4or 5-	+)	Homen	NOT usa retin	ed)		Own Hon	ne	
77. Fether's Nema (First, Middla, Las Michael Cannon	()					<sub>ima (First, Middla, A</sub> garet. McG		na)	
19a. Informant's Name/Ralationship John Murphy						Baltimore			
0a. Mathod of Disposition  1) Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Speci		camat	of Disposition tary, cramato	on (Name of ory or other pla			20c. Location -		
21. Signatura of Funaral Service Lice	gsae /	1 -		ame end Addr			Washing 1-Wiede		-
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The lew requires that the deam within 24 hours after death within 72 the Leneral Director: After this certificate has been signed by the enter completely filled in by the funeral director, page 2 should be detached for prompletely filled in by the funeral director, page 2 should be detached for prompletely filled in by the funeral director, page 2 should be detached for prompletely filled in by the funeral director.

State Registrar

30. Nema and addrass of person who completed ceusa of daath (Item 23a) (Type, Print)

CLEETMA RAJA, 4367 HOIIIN Feny Rd, Balt MD 21827

31. Data filed (Month, Day, Year)

SED 0.2 1000

32. Registrer's Signetura

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Be Completed

2

Medical Examiner

Be Completed by Physician

Medical Certification: To

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, it is Medical Examiner must be notified at once.

Physician

/Medical **Examiner** 

Baltimore, Maryland 21215-0020

SEP 0 3 1998



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day Month **Physician** Corine Mitchell 1998 25 2.00 AM Aug /Medical 4a. Fecility Nema (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nursing + Rehab Center Darting

| Nursing + Rehab Center Darting
| Some lest hirthday | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) VIlla St. Michael NIA 5. Social Security Number 6. Sex Birthplece (Steta or Foraign Country) 1 M 2 216-36-7169 98 Feb 04,1900 NC. Usual Rasidance of Decedant 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Md Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizan of What Country? 6800 Liberty Road Apt. 614 Funeral 21207 USA 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Reca - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 No If Yas, Give Yeer or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 █ No Specify: **Black** Ď 3 XWidowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grede complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 10th Housewife Domestic 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Be John Bradley P Lula Clapp 19e. Informent's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) (Daughter) Lorine Moore 3712 N. Rogers Avenue Balto, Md. 21207 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Crowell Bapt Ch Cem 8/29/98 Enfield, NC. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Fecility Caple Funeral Service 5502 Winner Avenue Baltimore, Md 21215 Entar the disaasa, or complications thet causad tha death. Do not antar tha mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximata Intarval Batwaen Immediata Cause (Final ALZIMENTS DEMENTIA diseese or condition rasulting in death) Comonte Dua to (or as a consequence of) Examiner Saquantially list conditions, if any, leading to Immedieta causa. Enter UndarlyIng Causa (Disaasa or Injury Due to (or as a consequence of): Physician/Medical thet initieted avants rasulting in daeth) Last Due to (or es e consequança of): Part II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed 212 No 1 Tyes 2 No Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify) Certification: To 1 Yas 2 No 27. Mannar of Death 28d. Describe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicida 281. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida edical 1 Certifying Physician: To the best of my knowladga, daath occurred et the tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and placa, and due to the ceuse(s) and mannar stated. 29a. Cartifiar (Check only one) 29b. Signatura end title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 1445931 o completed causa of death (Item 23a) (Type, Print) 30. Neme end eddrass of parson w Heights Avenue Baltimore MD Pierce Deborah

State Registrar 31. Data filed (Month, Day, Yaar) SEP 0 3 1998

32. Registrar's Signatura

**Funeral** 

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at

72 hours after death

filed within 7 Hygiene.

permit. Peges 1 and 2 should be filed.
Deperment of Health and Manlel Hygin Important: If them 27 is marked any Injury or other 27 is marked any Injury or other 27 is marked any English and Page 1.

**Physician** /Medical

Examiner

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After

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efter deeth Director:

24 hours e Hospital

within 2

filled in by

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

The law requires that the death certificete be-

or Attending Physician:

MITCHELL

ORRINE

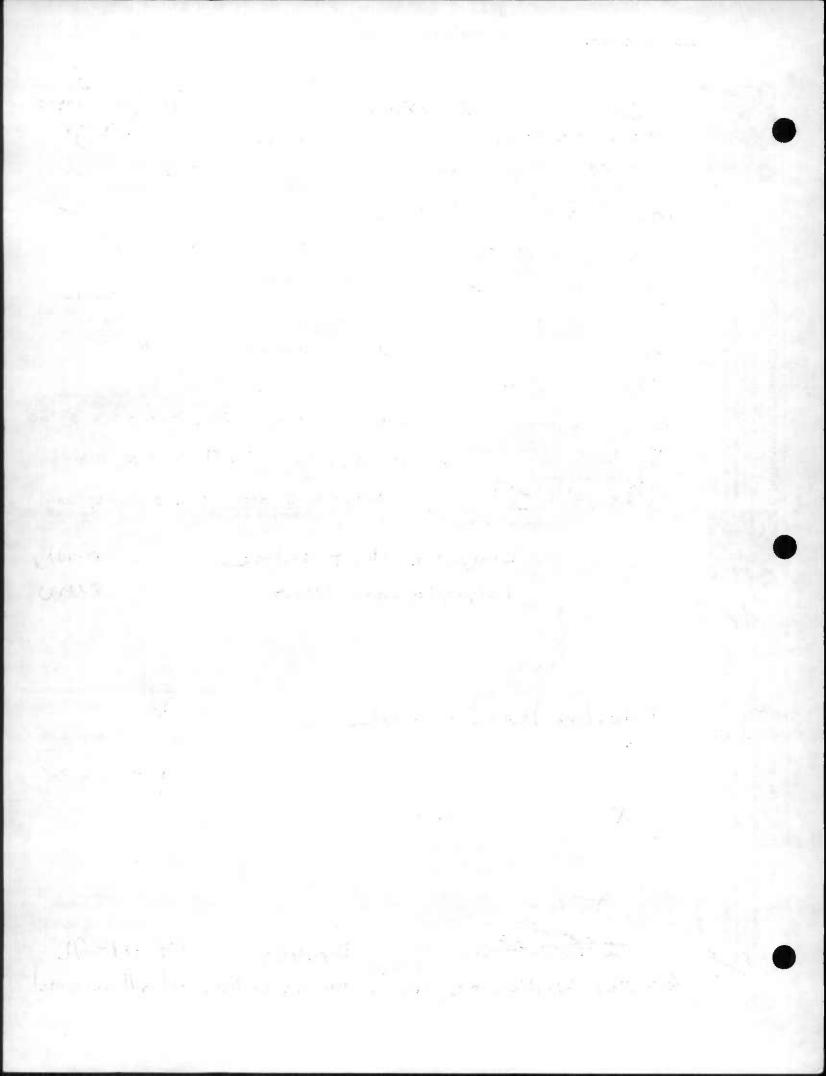
Cecil Matthews Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) **Physician** 30 98 ratthews 18:12 8 ecco /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Nama (If not institution, give street end number) Examiner NA Bon Secours Hosp. Battomore If Under 24 Hrs. 8. Date of Birth (Month, Dev. 3 - 13 If Under 1 Year 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days 112M 2□ F 219-07-9410 83 Yrs. Va. Director Usual Residence of Decedent with the Marylend 10a Stata 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner traus be notified at Baltimore 1 Tes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Honewood Are 21218 U.S.A. 2006 permit. Pages 1 and 2 should be filed within 72 hours efter deeth v Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Exa. wher insurances. Funeral Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - Amaricen Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Giva Yaar or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: by 3 ₩idowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Oyster College (1-4or 5+) Elementery/Secondery (0-12) Shucker Oyster unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) Jubilee Sadie Thomas P 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) 516 N. Franklintown Rd, Balto. , mo Jubilee 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State Garden 4 ☐ Dopetion 5 ☐ Other (Specify) MEM Joshell 21. Signature of Funeral Service Close 22. Nama end Address of Facility March F. H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner Ycy hemma The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): 23b. Did tobacco usa contribute to the causa of death? ed by the a Part II. Other atgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I signed by t No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to complation of ceusa of deeth? 24a. Wes en eutopsy performed? Completed peen : cartificete hes 1 Yas 2 No Division of Vital Physician: 25. Was cese referred to medical axaminar? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ENOutpatient 3 ☐ DOA P 24 hours after death.

Funeral Director: After this detely filled in by the funeral directly 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Tima of 27. Menner of Deeth 28c. Injury at Work? Certification: 5 Pending investigation or Attending 1 Accident 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Contriging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. (Check only one) within 2 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 0 MO 30. Name and address of person who complated cause of deeth (Item 23a) (Type, Print) Union memor SIMPLEX m.10

State Registrar 31. Date filed (Month, Dey, Year)

SEP 0 3 1998

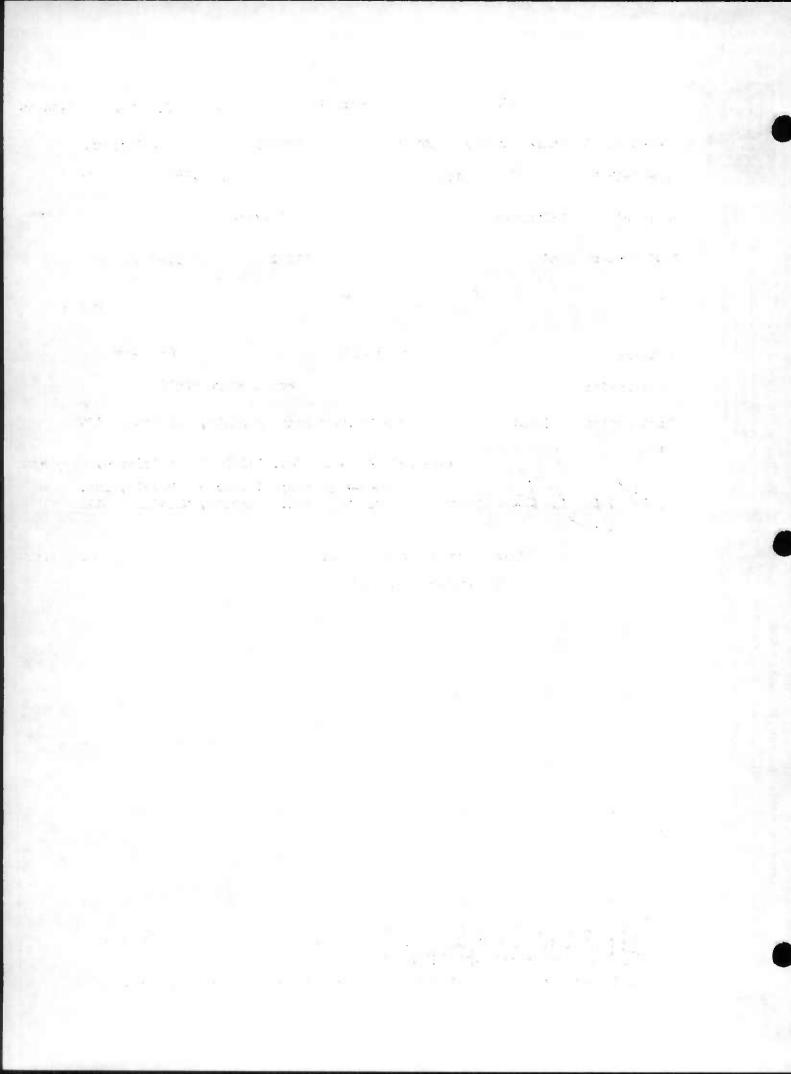
32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey **Physician** Madeline Morisi 30. 1998 August 5:50 AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Genesis Eldercare Heritage Center Dundalk If Under 24 Hrs. Baltimore 5. Social Securify Number Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dev. Yeer) **Funeral** Min 1 M 2 F Months Deys Hours Yrs Director 063-14-1709 Italy May 23,1896 102 Usuel Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Llmits "natural", or items 23a or 28a-f ahow 1 ☐ Yes 2 1 No Maryland Director Baltimore Dundalk 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? 1809 Dunmere Road Funeral 21222 United States 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ff Yes, Give Year or Detes: 1 ☐ Yes &☐ No Specify Specify P 3 Nidowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry The Medical and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife 4 Years Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fittened of Health and Mental Hant: If item 27 is marked oth jury or other traumatic even Be Paul Morisi Mary Rose Poggioli 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Dundalk, Paul Morisi (Son) 1809 Dunmere Road Maryland 21222 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1X Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If i any Injury or page. 4 Donetion 5 Other (Specify) Most Holy Redeemer Cem. 9/2/1998 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland eyer complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, List only one cause on each line. 21222 Approximete intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Coronary Artery Disease 12 years Examiner Due to (or es e consequence of) Examine Alzheimers Disease 6 years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): and Division of Vital Records, P.O. Box 68760 edical Due to (or es e consequence of) Physician/M Pert It. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? B 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown à 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed page 2 1 Yes 2X No 1 Yes 2 No ate director, 8 25. Wes cese referred to medicel examiner? 26. Piece of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: Naturel Attending 5 Pending Investigation 1 Yes 2 No 2 Accident Director 281. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could nof be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide after ö Funeral D hoors 29e. Certifier 💢 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted edical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 9 29b. Signut 29c. License number 29d. Date signed (Month, Day, Yeer) D14160 08/31/98 30. Name end eddress of person who completed cause of de eeth (Item 23e) (Type, Print) 5410-A Ritchie Highway Baltimore, Md. 21225 Harjit Singh, M.D. State ooks

Registrar



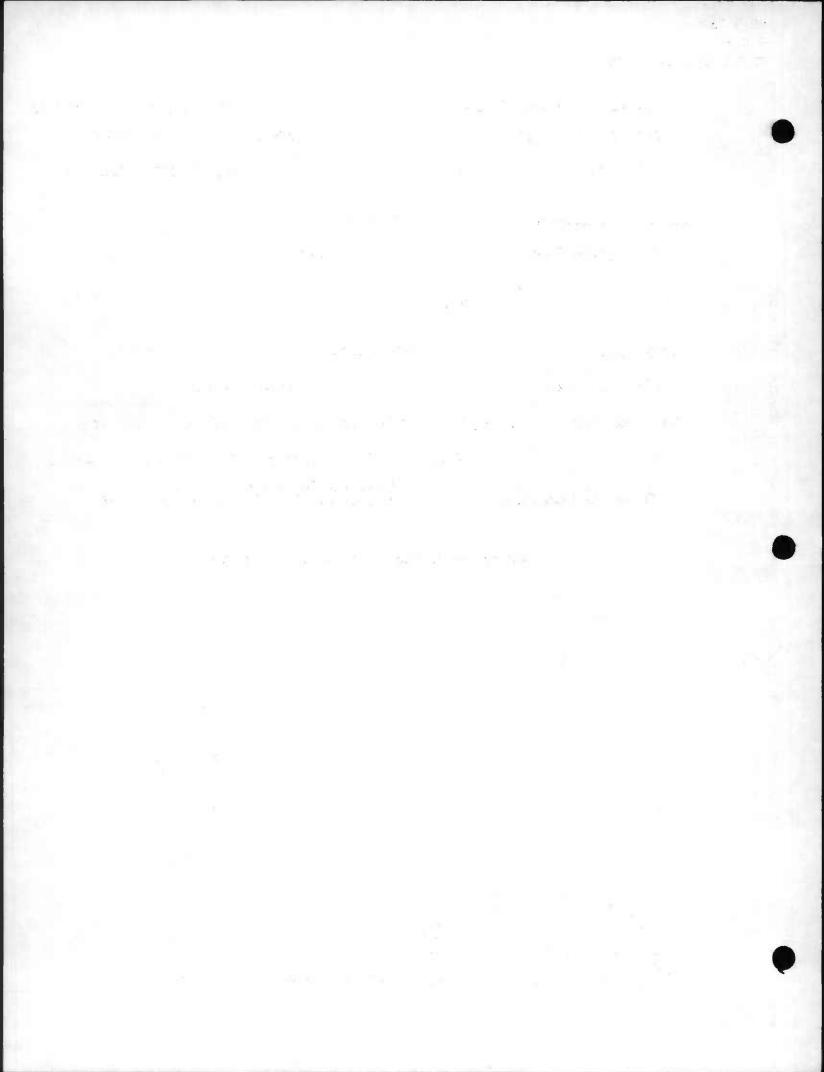
State of Maryland / F

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Examine		2 GREGWOOI					DUNDAL	K	BALT	IMORE	
Funeral		curity Numbar	6. Sex 1 M 2 □ F	7. Age (In yrs.	last birthday)	If Under 1 Y		s. 8. Date of Bird	th v Yearl	9. Birthplec	a (State or Foreign
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	23a. Part1.	. Enter the disease, c c, or haart failure. Li	or complications that st only ona causa on	caused tha deat each line.	h. Do not ente	er tha moda of	dying, such as cardia	ic or respiratory a	rrest,	i In	pproximate iterval Between inset and Death
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State Registrar

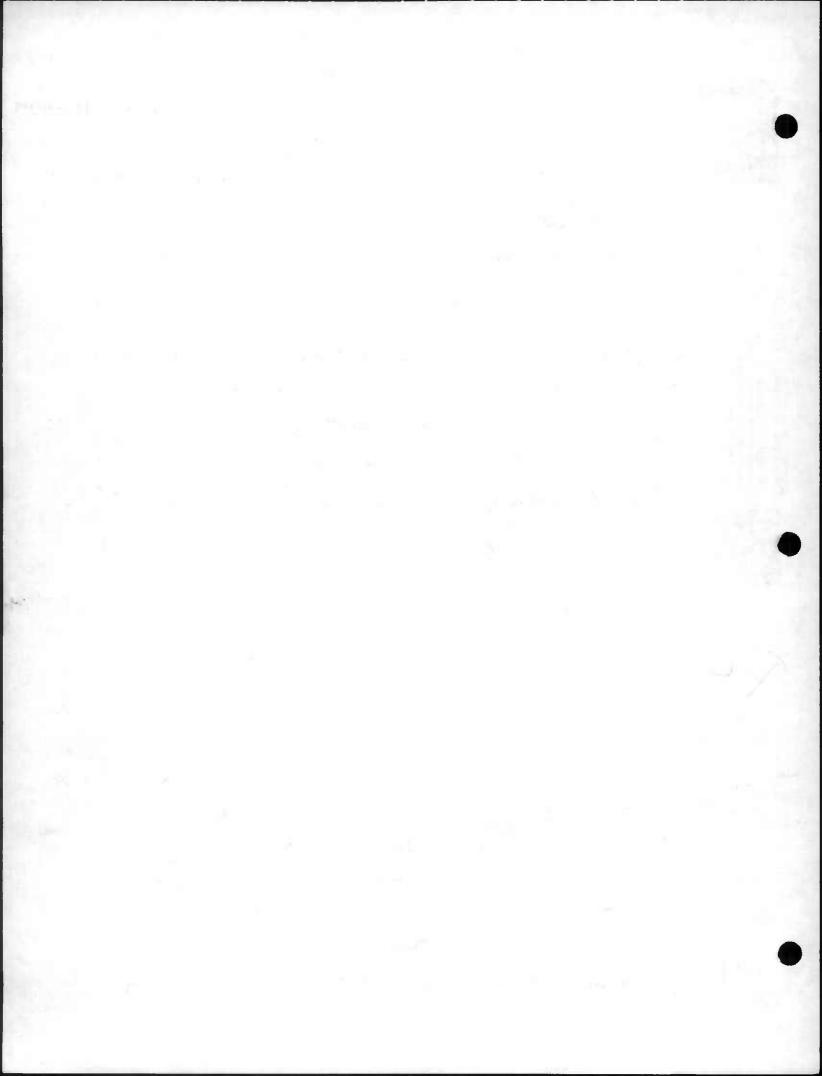
32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 2 6 9 3 |

					Certifica	te of	Death		Re	g. No.			
		1. Decedant's Name (First, Middle, Las	1)						2. Dete of Deet	h	Va		. Time of Death
/siciar ledica		Robert James McG	rath						August	31,	1998	iar	11-54An
iedica aminei	-	le. Fecility Name (If not institution, give	straat and number)				4b. City, To	wn, or Lo	ocation of Daath	-	County of E		
	ı	400 Forest Valley	Drive				Fore	st H.	ill		Harfo	rd	
ral tor		5. Sociel Sacurity Number 6. Se 048-20-1078		yrs. lest birti	rs. If Und	er 1 Year Days	If Under		8. Date of Birth (Month, Day, Jan. 15,			Birthpleca Country)	(Stata or Foreign
9		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location							10d.	Inside City Limits
normag	runeral Director	Maryland Harford	d	Fores.	t Hill	ip Code			10	Oa. Citiz	en of Whe		1 ☐ Yes 2X No
	I I	400 Forest Valle	y Drive		21	050				u.s			
1	2	11. Marital Stafus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forcas? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 19		13. Was Dec If Yes, sp	ecity Cut	oan, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		4. Race - A Bleck, V Specify:	Amarican I White, etc. Which	
100	ered	15. Decedent's Ed (Specify only highast grad	ucetion de completed)		Decedent's Us (Give kind of v	ork done	durina most	t of worki	ina		nd of Busine		ry
	Completed	12th grade	College (1-4or 5+)		ectrica			ian			troni unica		5
0	0	17. Fathar's Nama (First, Middle, Last)							e (First, Middle, N	feiden :	Sumema)		
1		James Thomas McG		104	Ada Stan - Addres			y Blo		0.4	T 01-	- T- O-	4-1
5		19a. Informant's Name/Relationship (7)							al Route Number,	-			
i du la	1	Edith M. Houck-Mo		Ob. Plece of	Disposition (N , cremetory or	ame of	accey	vice	ve, For	Oc. Lo	cation - City	or Town,	State
		1 X Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donetion 5 ☐ Other (Specify	)		y vall	ey M	em. Gra		9/3/98				
any injury		21. Signature of Funeral Service Licens  Buan G. W.			Schin 610 W	and Addr unek I. Ma	ess of Fecilit E Fune LcPhair	ral 1 l Ro	Home of ad, Bel	Bel Ai	Air,	Inc.	014
ian cai ner		23a. Part1. Enter the disease, or comp shock, or heert feilure. List only o Immediate Cause (Finel disease or condition resulting in death)	A 3	CVD				+					ervel Between set and Daath
Evaminar		Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events	b. Due	to (or es e c	onsequence o	):							
Marie Dunat-Trensit	2011	resulfing in death) Last	d.	to (or as a co	onsaquanca of	):							
eleia	100	Pert II. Other significent conditions co	ntributing to death but no	t resulting In	the underlying	cause q	iven in Pert I.		23b. Did to	becco	uee contrit	oute to the	cause of deeth?
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Patelo								1	24a. Wes er	n eutop ned?	sy 2	availat	eutopsy findings bla prior to etion of ceuse th?
bade d	5								1 ☐ Ye	s 25	No	1 □ Ye	es 2000
To Be		25. Wes case referred to medical axaminar?  1 Yes 2 □ No	Hospital: 1 ☐ Inpetient	2□ ER/Out	petianf 3 l	OA OI	hor:		me 5 A Reside		Other (	Specify)	
		27. Manner of Deeth	28e. Dete of Injury (Month, Day Yea	28b. T		28c. Inju			28d. Describe ho			2	
	2	1 ANeturel 5 Pending invastigation	NA		JA M		Yes 2	No	1	NA			
Medical Certification:		3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S	At home, far	m, street, facto	ory, office			28f. Location (St. City or Town	stete)		or Aural Ad	oute Number,
polical			elclen: To the best of my iner: On the basis of exe end menner stated.										
d los	- 1	29b. Signatyra and title of cartifiar	<u></u>	D	ME		se number	-			e signed (N		
-1	;	30. Name end eddress of person who c											
-		9 PRABHUM	0 0.000	3	A O O	111		. سم (	270	O 1	~ 1 / L		



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State of Maryland / Department of Health and Mental Hygiene 26932

Certificate of Death
Reg. No.

2. Date of Death
Month Day Year 3. Time of De

	Certificate of Death Reg. No.												
	Decedent's Name (First, Middle, Last)							2. Date of Death 3. Time of Death					
sician	DOROTHY COLLIER MCPHERSON								Month Day August 31, 199		7:45 PM		
edical	4a Facility Name (If not institution	TA	4b. City, Town, or Lo						, . 43 FW				
miner									Do l	+ i m = m =			
-	Gilchrist Center Towson Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or									State or Foreign			
<b>41</b>	1□ M 2□XF				Yrs. Months Days Hours Mi			8. Date of Birth (Month, Day, Year)  Apr. 11, 1905  9. Birthplace (State or Foreign Country)  Virginia					
r	216-03-1580 Usuai Residence of Decedent		93					Apr. I	1, 1905	A T.T.	ginia		
	10e. State 10b. County		10c. City	y, Town or Loc	cation					10d. fn	side City Limits		
-										11	□Yas 2⊠No		
Š	Md. Bal		Baltimore										
Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?												
<u>=</u>	212 Rogers Forge Rd. Apt. 'A' 21212								USA				
Je	11. Maritai Status	12. Was Decede	12. Was Decedent Ever in U,S. Armed Forces? 1			t of Hispanic	Origin? (Sp	ecify Yes or No	ify Yes or No-		e - American Indian,		
Funerai	1 Never Married 2 Marri	ed 1 Yes 2				If Yes, specify Cuban, Mexicen, Puerto Ricar  1 ☐ Yes 2 ☑ No Specify:  Decedent's Usual Occupation			Biac	liack, White, atc.			
by	3 ☐ Widowed 4 ☑ Divorced								Specify		White		
8	15. Decedent	's Education							16b. Kind of Business/Industry				
Completed	(Specify only highes		(Give kind of work dona during most of working life, DO NOT use retired)				king	g					
E	Elementary/Secondary (0-12) College (1-4or 5+)												
ဒ	12		Home maker				40 - 1 - 01	Own home					
Be	17. Father's Name (First, Middle, Last)					18. Mother's Name (First, Middle, Maiden Sumama)							
9	Joseph Henr	cy Colli	ier			Ma	ry	Elizabeth Thomas					
	19a. fnformant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (S	Straet and Nur	mber or Rui	ral Route Number, City or Town, State, Zip Code)					
	Mr. Alvin C. Mo	Pherson/so	on	1703	Welfor	rd Ct.	Luth	erville	, Md. 21	.093			
	20a. Method of Disposition			Place of Disposemetery, crem				Date		City or Town, S	State		
	1⊠ Burial 2 ☐ Cremation	3 ☐ Removal from Sta	ate	emetery, cren	atory or othe	r place)	1						
	4 Donation 5 Other (Sp	pecify)	Dula	aney Va				9/3/98	Timoni	ım, Md.			
	21. Signature of Funeral Service Licensag 22. Name and Address of Facility												
	Jethur J. Jair Ruck Towson Funeral Home, Inc.												
	23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
	23a. Part1. Enter the disease, or complications that ceusad the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death												
	formediate Ceuse (Final disease or condition resulting in death)  a. probable metastatic lung Concer 1 month												
	resulting in death)  Due to (or as a consequence of):												
Examiner													
E	b. Due to (or es e consequence of): if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated events  Due to (or es e consequence of):												
EX													
cal													
P	resulting in deeth) Last  Due to (or as a consequence of):												
2	d.												
an													
Sic	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.							23b. Dld	23b. Did tobacco use contribute to the cause of death?				
Physician/								1	1 Yes 2 No 3 Probably 4 Unknown				
									-71				
d by	24a. Was an autopsy 24b. Wera autopsy findings												
Completed									performed? available prior to completion of ce of death?		e prior to		
pid													
E								10	Yes 2 No	1 Yes	2 □ No		
0	25. Was cese referred to medical					oc D	lace of Dec						
Be C	examiner?	Hospital:				Other:		th (Check only		10 /	1		
2	I impatient 2 ENVOLIDatient 3 DOA 4 Housing Notice 3 Decimental										tospia		
OU	27. Manner of Death  Natural 5 ☐ Pending	28e. Dete of fnjury (Month, Day Year) 28b. Time of injury 28c. Injury et Work? 28d. Describe how injury occurred											
ati	2 Accident investigation M 1 ☐ Yes 2 ☐ No												
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
en l	→ □ Holdicide	4 ☐ Homicide building, etc. (Specify)								Ony or Town, State)			
C	29a. Certifier 1 Certifying	g Physician: To the be	ast of my kno	wledne death	occurred at t	the time date	and place	and due to the	cause(s) and m	anner es steted			
edicai	(Check only 2 Medical E	examiner: On the basi	is of examine										
Med	one) and manner stated.												
~	29c. Signature and title of certifier 29c. Licansa number							29d. Data signed (Month, Day, Year)					
	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)  W. A. R. (Le., G. & M. Charles St. B. L. C.								September I, 1998				
1	30. Name and accress of person v	Mo completed source	of death (line	23a\ /T.mc	Print\					- /			
	2. Name and accress of person (	. 4		PI -	Par C+	6.	Chain	Sure 1	nd 21	204			
	With Killy (	, -			~ 3/			1		/			
State	31. Date filed (Roll DDA), Year	000 32. Aeg	istrar's Signa	ture									

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Registrar

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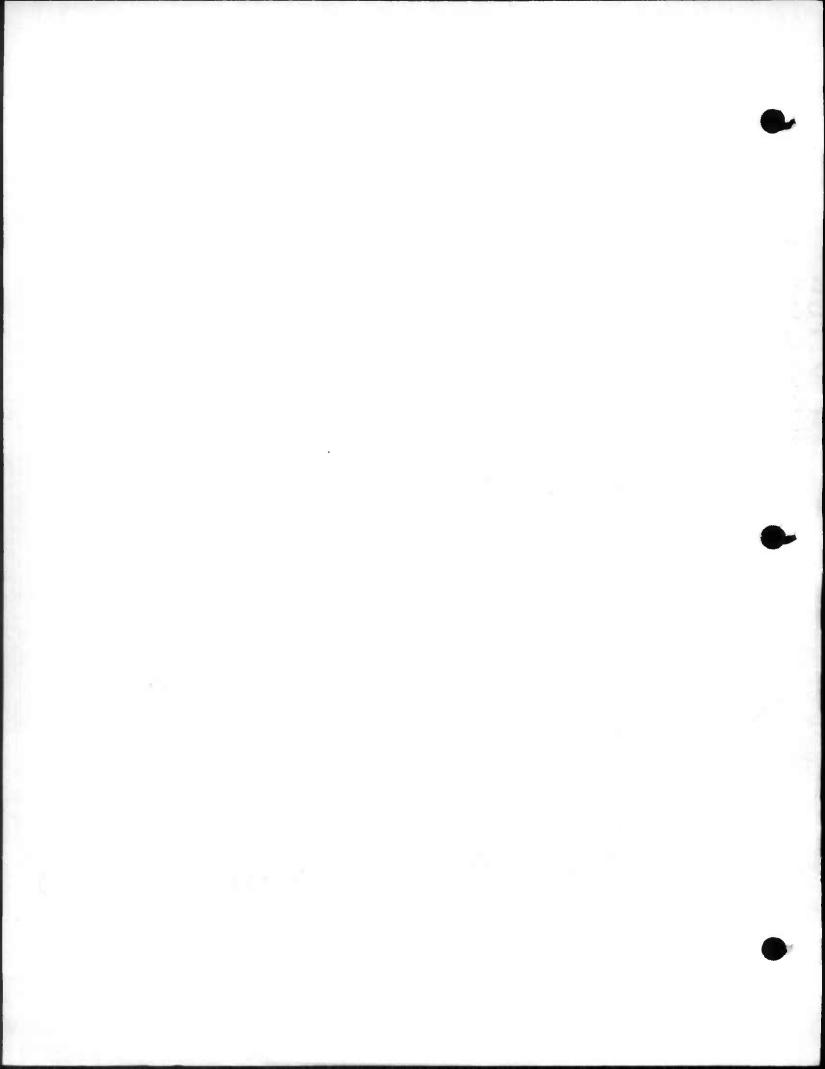
stree death. Page 6 may be retained by the hospital or attending physician.

The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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THE HOSPITAL DR ATTENDING PHYSICIAN: The law the set into the death certific THE FUNERAL DIRECTOR: After this certificate fies the law of the attending plant of the set of the set with the State Dept.  **ORTANT: If item 28 is marked, or item 23 show by injury, or other and the set of t	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The jaw makes that death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been made to be the attending physician and completely filled in by the funeral director, page 5 should be detached for upe filled within 72 hours after death with the State Dept. Carama and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows my injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFIC			MENTAL HYGIENI	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Baby Brittany	McKinney				AUGUST 2.		5:29 P M
	4. SOCIAL SECURITY NUMBER	The second secon		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH Count	IPLACE (State or Foreign
	N/A	1 🗆 M 2 💢 F	- YRS.	UAYS	HOURS MIN.	Aug. 25,1	998   Ma	ryland
œ	9a. FACILITY NAME (If not institution, give s	treet end number)	96	CITY, TOWN C	R LOCATION OF DE	EATH	9c. COUNTY OF D	EATH
DIRECTOR	GREATER BALTIMO	RE MEDICAL CE	ENTER	TOWSO	N		BALTI	MORE
R	10e. STATE 10b. COUNT	Y	10c. CITY, TO	OWN OR LOCAT				10d. INSIDE CITY LIMITS?
		timore		Baltin	ore			1 TES 2 NO
FUNERAL	6213 Ebenezer R	load		101	ZIP CODE	000	10g. CITIZEN OF V	
N.	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	II.C. ADMED	40 1110 1110		220		.S.A.
	1 Never Married 2 Merried	FORCES? 1 YES	2 NO	If yes, sp		IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	Black	— American Indian, k, White, etc.
BY	3 Widowed 4 Divorced	II TES, GIVE WAN ON DA		I TES	ZA NO Specin	<i>r</i> :	Speci	"White
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USU (Give kind of work	done during mo	N st of working	16b. KIND OF BUS	INESS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use ret				\$1 / A	
<u> </u>	17. FATHER'S NAME (First, Middle, Last)		14/	Α	40 MOTUEDIO NA	ME (First, Middle, Malden S	N/A	
	Jason Eberwei	n			Tamm			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	DRESS (Street a		Route Number, City or Town	2	
임	Tammy McKinney	(mother)				Baltimore,		20
	20a. METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Rem	oval from State	PLACE AND DATE OF DI	SPOSITION (Na	me of	DATE 20c. LOC	ATION — City or To	wn, State
	4 Donation 5 Other (Specify)	Hõ	lly Hill	Memori	al Gard.	8/28 Bal	timore, 1	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		Sch	muner Fi	uneral Home	e. Inc.	
	Melle	4		970	5 Belair	Rd. Balt	imore. Mi	21236
	23. PART I. Enter the diseases, or cashock, or heart feilure.	complicetions thet caused List only ona cause on aa	the deeth. Do not a	anter the mo	de of dying, sucl	h as cardiec or reepir	atory errest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition	Heart Fai	iluro				Onset and Death	
	resulting in death)	8	CONSEQUENCE OF):					
_			ity 18 we	eks				
2	Sequentially list conditions, if any, leeding to immediate		CONSEQUENCE OF):					
2	CAUSE (Disease or injury	Termination		nancy	for anom	alies		
Ë	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION		1						
A	PART II. Dther significant condition	s contributing to death bu	it not resulting in th	e underlying	ceuse given in	Part I. 24s. WAS AN A	WTOPSY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						1 YES 2		COMPLETION OF CAUSE OF DEATH?
ž	DID TOP LOCAL HAT CONTENT							1 TYES 2 NO
PHYSICIAN	DID TOBACCO USE CONTI		6. PLACE OF DEATH (C		UNCERTAIN	1 🗆 📗		
S	EXAMINER?	HOSPITAL:	ОТ	HER:	4.00			
Ĭ	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. INJU	5 ☐ Residence	28d. DESCRIBE HOW IN	JURY OCCURED	
BY P	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	INJURY	M 1 Y	RK? ES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY - building, stc. (Specif	- At home, farm, atreel	, factory, office		281. LOCATION (Street or City or Town, State)	nd Number or Rural R	loute Number,
COMPLETED	4 Homicide determined					on, or norm, orano,		
릴		CIAN: To the best of my knowle						
် ဂြ	2 MEDICAL EXAMINE	R: On the basis of examination	end/or investigation, in	my opinion, de	ath occured at the	time, date and place, end	due to the cause(e	end manner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	wer			29c. LICENSE NUM		29d. DATE SIGNED	(Month, Day Year)
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPONE ET ED CONTROL	THE STREET		D 38	840	1	78 19X
					Totacon	, Maryland	21204	
	W. Scott Supplee	32, REGISTRAR'S SIGNA		169 36	. TOWSOII	, maryranu	21204	
	SEP 03 1998	Beneva	D. So	usal				
			7					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Deeth 3. Time of Death Month Q 715 VICGINIA MULTAY 4b. City, Town, or Location of Deeth 4a. Fecility Neme (If not institution, give street and number) 4c. County of Deeth Long View Nursing Home Carroll Manchester Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth North, Date Open 1916 9. Birthplace (Stete or Foreign North, Date Open 1916 9. Bent Co., 213-03-0635 1 M 20 F Maryland Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Md. Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21074 U.S.A. 4100 Maple Grove Road 12. Was Decedent Ever In U,S. Armed Forcus? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Raca - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White 3. Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaking 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Dora James Wink Rachel Emily Lippy 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4100 Maple Grove Rd. Hampstead, Mg1074 daughter Brenda R. Murray 20a Mathod of Disposition

1 Decrease 2 Cremetion 3 Removel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Manchester 4 ☐ Donetion 5 ☐ Other (Specify) New Lutheran Cemetery Sept. 5, 1998 22. Name and Address of Fecility 3296 Charmil II Service Licensee Drive Manchester, Maryland 23a. Perff. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Betw Immediate Ceuse (Final diseese or condition resulting in death) SEPTICEMIA Due to (or es e consequence of): URINARY TRACT INFECTION Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown ALZHEIMER'S DEMENTIA 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 10 No 1 Yes 2 No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner that the death certificete be executed P.O. Box 68760, Records, page 2 Division of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifice stelly filled in by the funeral director, p

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show must be notified at

8

Items 23s

'natural', or

Hygiene.

Pages 1 and 2 should be filed vinent of Health and Mental Hygin nnt. If flem 27 is marked other

Department of Health as important: if Nem 27 is any Injury or other trau

**Physician** /Medical

Baltimore, Maryland 21215-0020

Director

þ

Completed

Examiner Physician/Medical þ Completed Be Certification: To

edicai

State

Registrar

25. Wes case referred to medical examiner? 1 Yes 27. Menner of Deeth 1 Neturel

3 Sulcide 6 Could not be 4 ☐ Homicide

Location (Street end Number or Rurel Route Number, City or Town, State)

12 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29b. Signeture end title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)
Deogracias Faustino, M.D. 411 Lower Beckleysville Rd. Hampstead,

Me P

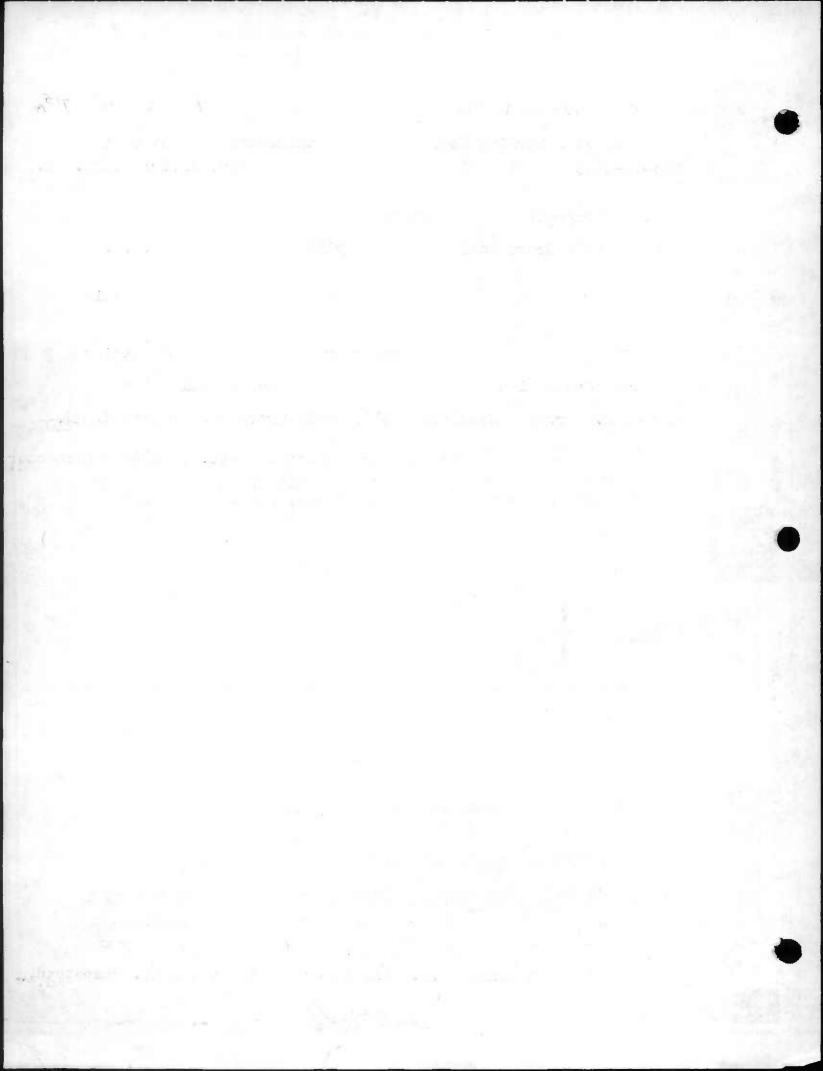
31. Dete filed (Month, Day, Year)

SEP 0 3 1998

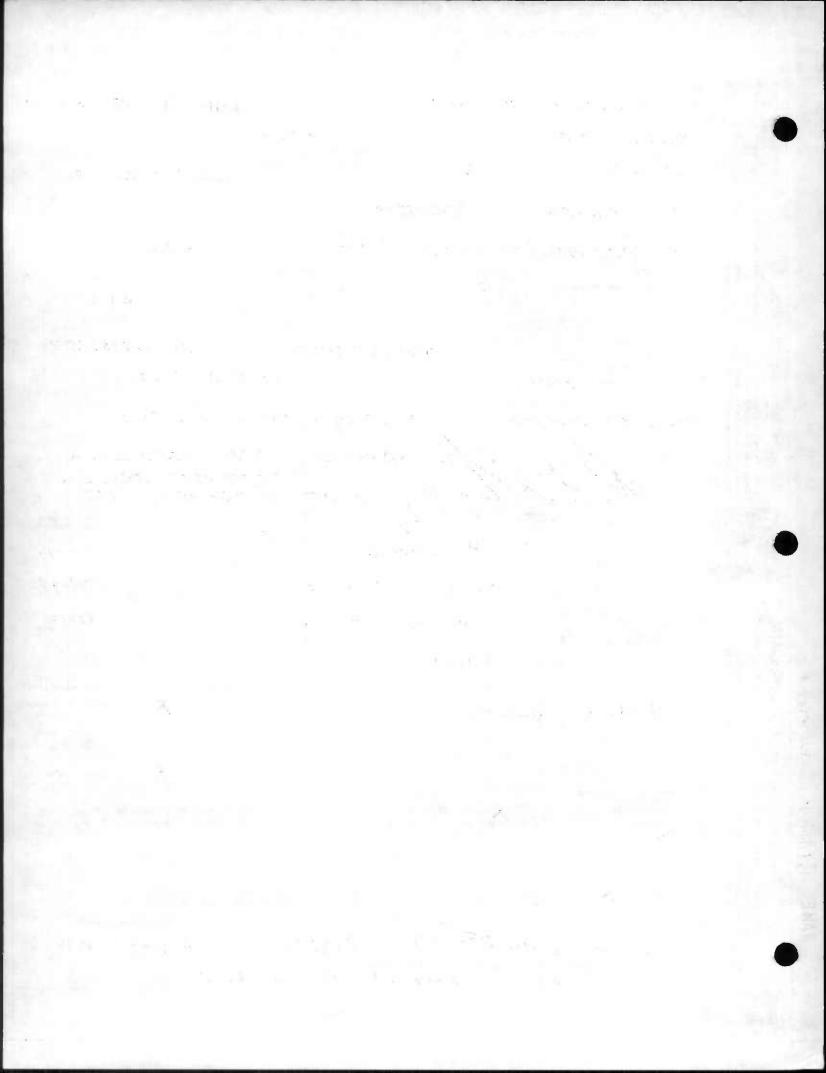
32 Registrer's Signeture

24 hours a

To the Hosp within 24 hou To the Fune completely fil



				Certifica	te of	Death		Reg. No.		
	1. Decedent's Name (First, Middle, Last,						2. Dete of D	eeth	Year	3. Time of Deat
Physician - /Medical		mum	mert				AUG	Day 31	<b>98</b>	07:47A
Examiner	4a Fecility Name (If not institution, give					4b. City, Town, o	r Location of Dee	th 4c. Cour	nty of Death	
	ST. AGNES HOSPITAL		to at his	the day of the land	er 1 Year			inth	O Diah	-lass (Ctata as Fam
Funeral Director	212-03-0442	х М 20 F 10:	e (In yrs. lest bir 2	Yrs. Months			n. (Month, D	8. Date of Birth (Month, Dey, Year)  JAN 29, 1896  MARYLAND		
ehow	Usual Residence of Decedent  10e. State 10b. County	W 5 54	10c. City, Town							10d. Inside City Lim
e Mary	MD BALTIMORE		CATONS	VILLE						1□ Yes 2☐
deeth with the Maryland ms 23s or 28s-f ehow creat be notified at	10e. Street end Number 31 GLENWOOD AVENU	E, CATONSV	ILLE,MD		ip Code 1228			U.S.A		ntry?
b 2 2	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Dec If Yes, sp	ecify Cul	Hispenic Origin? can, Mexican, Pue Specify:	(Specify Yes or N erto Rican, etc.)	8	lace - Ameri lack, White cify: WHI!	, etc.
5-00			16e.	Decedent's Us	uel Occu	petion during most of w	vorkina	16b. Kind of		
Maryland 21215-0020 d 2 should be filed within 72 hours eft filth and Mentel hygiene. The marked other than "natural", or treumatic event, the Wadical Exart To Re Completed by F	Elementery/Secondery (0-12)	College (1-4or 5		life. DO NOT	use retire	9d)	Orking	C&P TF	T.EPHO	NE COMP
d 2			OPE	RATOR S	UPER	-1-	eme (First, Middle	C&P TELEPHONE COMP (First, Middle, Maiden Sumeme)		
d be fi		ERTY					Y ELLEN	LILI		
should limerke	19a. Informant's Name/Relationship (T)		19b	. Mailing Addre	ss (Stree	at end Number or	Rurel Route Num	ber, City or Tov	vn, Stete, Zi	ip Code)
Ma nd 2 saith ar aith ar 27 ls r treu	MARTHA MUMMERT-DAU		3	1 GLENW	OOD	AVE, CAT	ONSVILLE	E, MD 2	1228	
Baltimore, Maryland 21215- permit. Pages 1 end 2 should be filed within 72. Department of Health and Mentlel Hygiene. Important: If item 27 is marked other than "nat enty injury or other treumetic event, the Median page. To Be Complete	20a. Method of Disposition  1 ☑ Burial 2 □ Cremettor 3 □ F  4 □ Donetion 5 □ June (Specify)	Removal from State		f Disposition (N ry, cremetory or HN S CE			Date 9/3/98	20c. Location		
Baltil permit. F Department Importan eny Injure	21. Signature of Eugeral Service Liberal	. //	21000	22. Name	and Addr	ress of Facility	ITZKE FU	JNERAL I	HOMES	, INC.
	23a. Part1. Enter the diseese, or compl shock, or heart failure. List only or	ications that caused	the deeth. Do			DSON AVE			1 Z	Approximete Interval Between
- Physician	shock, or heart failure. List only or	ne ceuse on eech lir	ne.							Onset and Deeth
/Medical	Immediate Ceuse (Final disease or condition	F	neum	onia						5 days
Examiner	resulting in death)	a	Due to (or as e		i):					
P # E		Ac	HR 1	enal	fai	lure			i	5 days
be Executed be Executed burial-trensit	Sequentially list conditions,	Due to (or as e consequenca of):  Chronic heart failure							***	Years
cate be an physician s the buria										
rtificate ng phys as the	resulting in death) Lest  Due to (or as e consequence of):									y cars
death ce death ce attendii		d								
O, the de ched	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting l	n the underlying	cause g	iven in Part I.	23b. Did tobacco use contribute to the cause of			
S, P.O. BOX ss thet the death ce gned by the attendi be detached for use by Physician/	Vertigo, o	glavcoma					_ 10	Yes 200 N	o 3⊡Pr	obably 4 Unkn
cord require been si should		,					24e. We	s en eutopsy formed?	a	Vere eutopsy finding vailable prior to completion of cause of death?
Rec he law te has the ege 2 s							10	Yes 2 No		□Yes 2NO No
/ital						26. Plece of D	eeth (Check only			
hysicle all direc	examiner?	lospital:	nt 2 ER/Ou	utpatient 3 1	OOA O	ther: 4 Nursing	Home 5□Re	sidence 6 🗆	Other (Spec	ify)
O D og Ph ter th nerel nerel		28a. Dete of Injur	y Year) 28b.	Time of Injury	28c. Inj	ury et ork?	28d. Describe	how injury oc	curred	
Sion andin or: Aft ha fu	2 Accident investigation			М		Yes 2□No				
Division of the or Attending Prastitudesh.  All Director: After ted in by the funer Certification.	3 Suicide 6 Could not be determined	28e. Placa of Injubuilding, etc.		erm, street, facto	ory, office		28f. Location City or T	(Street end Nu own, State)	m <i>ber or R</i> u	rel Route Number,
Division of Vital Rec To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Compl	29e. Certifier (Check only one) Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sician: To the best oner: On the basis of end manner ste	exemination en							
To the To the comp	29b. Signature end title of certifier	~ -	/	2	9c. Licer	nse number		29d. Date sig	ned (Month	i, Day, Year)
4	David by	trent	$\rightarrow$ , $m$		PIZ	1590		Augu	5+ 3	1,1998
.0	30. Name and address of parson who co		eath (Item 23a)		N	lorylond	2122	9		11
Ctoto	21 Date filed (Month Day Year)		ar's Signature	1 0	)	-17000	71172	ø		
State	SEP 0 3 1998	Gener	me /	9. 10	a W					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month **Physician** MACK DORIGI 1210 4b. City, Town, or Location of Death 31 98 /Medicai 4a. Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner Of Malyland Shock Trayna Center 8 Sex 7. Age (In yrs. lest birthday) If Undar 1 Year University Baltimore 5. Social Security Number Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 04/15/1963 9. Birthpleca (State or Foreign Country) NORTH CAROLINA **Funeral** 1 M 2 F Months Days Hours Min 35 245-11-0166 Director Usual Rasidence of Decedent with the Maryland 10a Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2000No Director MD ANNE ARUNDEL SEVERN 10e Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1774 LASALLE PLACE 21144 U.S.A. Funeral 12. Wes Decedent Evar in U,S. Armed Forces? ¼¼4as 2 ☐ No if Yes, Give Was Dacedent of Hispenic Orlgln? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merriad 2 ☐X Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK ò if Yes, Give Year or Dates: 3 Widowed 4 Divorced "neturel". Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 2+ than Eiementery/Secondary (0-12) AIRSPACE OPERATIONS NCO US AIR FORCE permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If Nem 27 Is marked other any Injury or other \*\*\* 17. Fether's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be SYLVESTER DeBERRY MARIE MCNEILL 2 19e. Informent's Neme/Relationship (Type Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RICHARD STEVEN MACK/HUSBAND 1774 LASALLE PLACE SEVERN, MD 21144 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete HILLSIDE MEMORIAL PARK 1 Burial 2 □ Cramation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/5/98 LAURINBURG, NC CEMETERY 21. Signature - Funerel Service Licensee 22. Name and Address of Facility
STERLING ASHTON FUNERAL HOME, INC. tack 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not entar the moda of dying, such as cerdiac or respiretory errest, shock, or haert failure. List only one ceuse on each line. Approximete Intervel Between Onsat end Death **Physician** /Medicai Immediate Cause (Final · multiple organ facture disease or condition resulting in deeth) Examiner Half as the Heat trumber of days

CA 23b. Did tobacco use contribute to the cause of death? Examine Subdural Hematoma

Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Do on motor Vehicle Crash Physician/Medical Due to (or es e consequence of) Pert il. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 1 Yes 2UNO 3 Probably 4 Unknown The law requires that ARRUST-Records, þ 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? 1 ☐ Yes 2 VNo certificate 1 ☐ Yas 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 2 1 Yes 2 No After this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Attending 5 Pending investigation 1 Naturel Injury 0800 AM death. 1 🗌 Yes 2 No 8124198 Vehicle 2 Accident motor CROSH after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide 2) RT 176 HANDUZR, MOL ROadWAL RT 170 To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name end eddress of person who completed bause of death (fem 23e) (Type, Print)

R. Adams

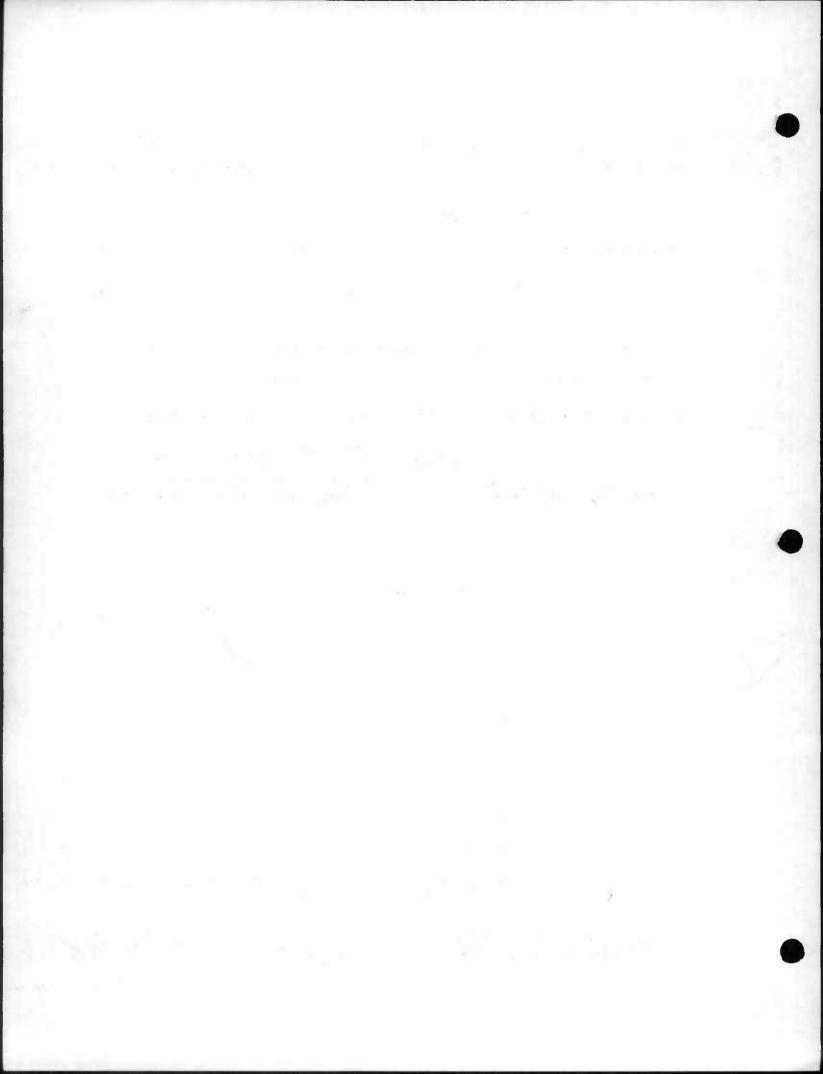
32. Registrer's Signeture

Cowley Shock Trauma, 22 S. Greenest, Baltimore

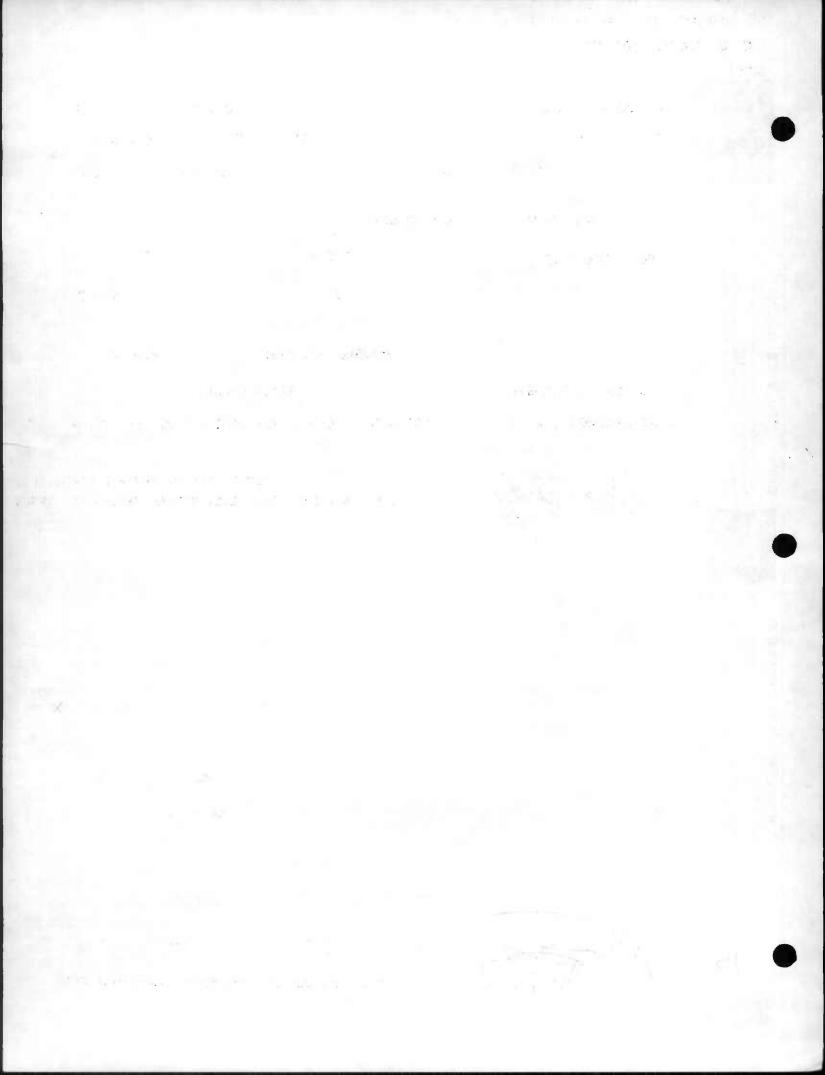
State Registrar Neal

31. Data filed (Month, Day, Year) SEP 0 3 1998

Rey nolds



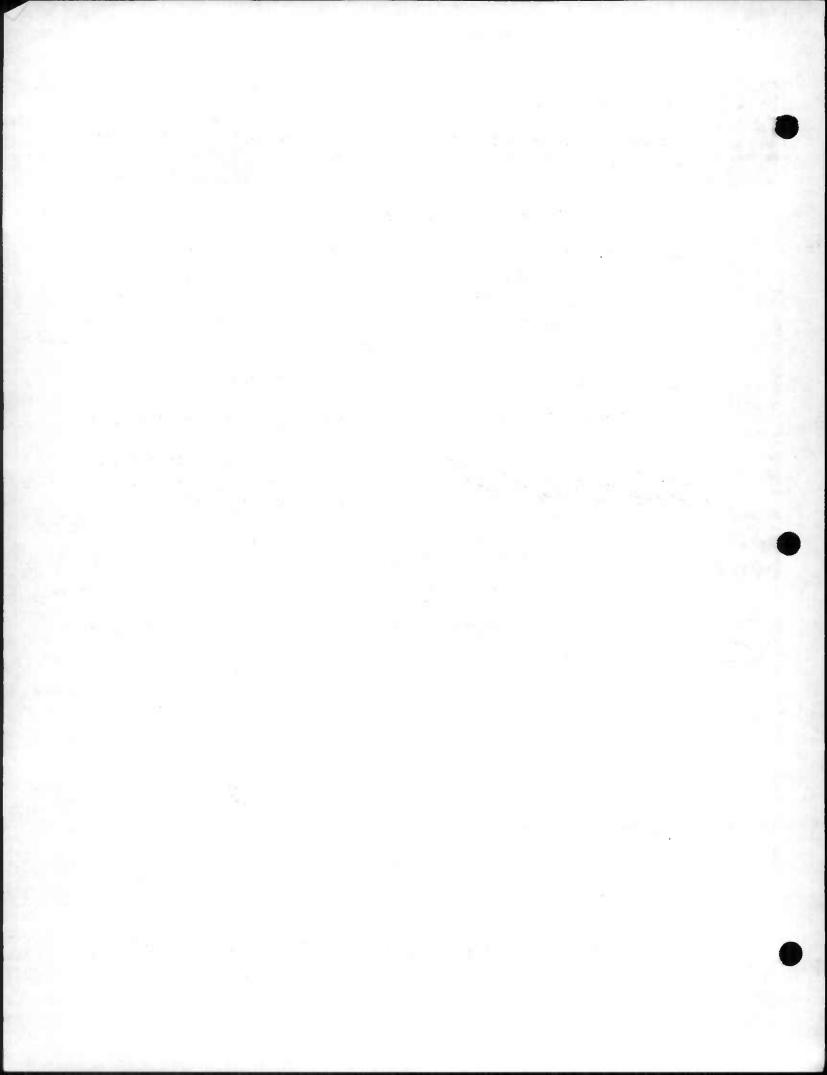
(	98-4960	-03	I Item 5 Per FH	Film	G769 3-9-9	9 rja	Plack Inc	dellble	lnk	Accura	All Capies	Arolo	aible		
(	GEORGE	NA	THAN MICHAEL	ease	State of I	Marylar	nd / Dena	rtmen	t of H	lealth and	Mental H	vaiene	gible.	693	37
2	ASP ITEM	1S:	#8,23PART I, 27, 2	8A_F			WK.			Death		Reg. No.			•
			1. Decedent's Neme (First, Mi			00 5 0	30			1015	2. Dete of D Month	eeth Day	Yeer	3. Tim	e of Deeth
	Physic /Medi		GEORGE N. M								AUGUS	ST 22	1998		00 P
	Exami	ner	4a Facility Name (If not instituted 600 CANNON			er)				4b. City, Town, or SILVER	SPRING		inty of Death		
	Funeval	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 H							If Under 24 Hr		irth Year) 19			ite or Foreign
	Funeral Director		5/8 <del>478=</del> 74-5763	X	XM 2□ F	50		Months	Deys	Hours Mir	MARCH	25, 19	98 E	intry) EGYPT	
	pue *		Usual Residence of Decedent 10a, State 10b, Cou	ntv		10c C	ty, Town or Lo	cation						10d Insid	e City Limits
	deeth with the Meryland ms 23e or 28e-f show	or		TGOM	FDV		LVER SI								res 2 No
	r 28a	Director	10e. Street end Number	10011	LILL	זנ	IC Mayn.	10f. Zip				10g. Citizen	of What Cou	intry?	
	th with	a D	600 CANNON	ROAD					2090	)4			USA		
	Reme Nerre	Funeral	11. Maritel Stetus		12. Wes Decede Armed Force	s?	J,S. 13. V	Vas Dece	dent of H	lispenic Origin? ( en, Mexican, Pue	Specify Yes or N rto Rican, etc.)	14. [	Race - Amer Bleck, White		٦,
120	a a	by F	1 ☐ Never Merried 2 ☒ N 3 ☐ Widowed 4 ☐ Divore		1 ☐ Yes 21 If Yes, Give Year or Date	1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ XN				Specify:		Spe	ocity: WF	IITE	
21215-0020	2 hours		15. Dece	lent's Edu	ıcatlon		16e. Deced	lent's Usu	el Occup	pation		16b. Kind o	f Business/li	ndustry	1 12
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Maryland	a de de	To Be (							namej						
aryl	Short A br		17. Father's Name (First, Middle, Last)  NATHAN G. MIKHAIL  19a. Informant's Name/Reletionship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route I										wn, State, Z	ip Code)	
			CLAIR MICHAEL	/ 1	WIFE					D SILVE	R SPRING	MARYL	AND 2	0904	
Baltimore,	of Health		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crematic	n 3 □F	Removal from Sta		Plece of Dispo cametery, cren	sition (Nat natory or c	ne of other plac	се)	Dete	20c. Locati	on - City or T	own, Stet	Ð
E	tment tant:	1	4 Donation 5 Other	(Specify)	1		rt Linc				8/28/98	Brenty	wood M	aryla	and
Bal	Department of the popular of the pop		21. Signature of Pureral Service Usinsae  22. Name end Address of Fecility HINES-RINALDI FUNERAL HOM: 11800 NEW HAMPSHIRE AVE. SILVER SPRING MD											E, INC.	
		0 1	23a Perti. Enter the disease	or define	lications that caus	sed the dea							SPRIN	Approx	20904 mate
	Physician		23a. Pert <sup>1</sup> . Enter the disease shock, or heart tailure.	ist only o	ne cause on eac	h line.								Onset e	Between and Deeth
	/Medical	П	Immediate Cause (Final disease or condition e. DRUG (PENTOBARBITAL) INTOXICATION e.												
н	Examiner	L.	resulting in death)		ө		or as e conseq								
	acuted and trensit	amlner		•	b										
Ć,	be execu sician end bunel-tre	Exai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			Due to (	or as a conseq	uenca of):							
1760	icata be physicia s the bur		Ceuse (Diseese or Injury that initiated events	5	c	Due to (	or es e conseq	uence of):							
Box 68760,	ing ph e as th	Med	resulting in death) Last	L		540.0 (4. 550 54.65(4.5.05 5.).									
Bo	The law requires that the death certificate be exatte has been signed by the attending physician eage 2 should be detached for use as the buriel	Physician/Medical			u,										
o.	that the de ed by the a detached	nysk	Pert II. Other significant cond	itions co	ntributing to deat	h but not re	sulting In the u	nderlying o	ause giv	ven in Part I.		d tobacco use			
0	gned by be deta	by Pt									- 10	J Y⊕⊕ 2 □ F	10 3∐PI	obabiy	4 Winknown
ords	v requires been sig should b	pe H									24a. We	s en autopsy formed?	€	vaileble p	osy findings rior to
ecc	hes be	plet											0	ompletion death?	ot cause
<u>~</u>		Completed									K	JYes 2□N	0 1	Yes	2□ No
Division of Vital Records,	Physician: The raths certificate and director, pag	Be	25. Was case referred to med examiner?	100	Hospital:				Ott	ner.	eeth (Check only				
o	Phys ral di	. To	1XXYes 2 No 27. Manner of Death		1 □ Inp	njury	28b. Time of		DA J 28c. Injui Wo	4 🗆 Nursing	Home XXRe	sidence 6 L a how Injury of		ify)	
ion	Attending Isr death.	ation	1 Naturel 5 Per 2 Accident inve	iding estigation	FOUND: 8-	Day Year)	FOUND: 9		Woi 1 □	rk?  Yes 2∐XNo	SUB	JECT ING	ESTED D	RUG	
Vis	or Attendi after death Director: A	tifica	3 Suicide 6 □ Cou	ild not be ermined	28e. Place of building.	Injury - At h	nome, ferm, str	eet, factor	y, office			(Street and Nown, State)			
۵	Hospital or 24 hours after Funeral Directory filled in	Cer										SPRING, N			AD MD
	Hosp 24 hou Fune staty fi	edical Certification:	29a. Certifier 1 Certification (Check only one)	ying Phy al Exami	sician: To the be ner: On the basis and manner	s of examina	owledge, deeth ation and/or inv	occurred restigation	at the til	me, dete end plac opinion, death oc	ce, end due to the curred et the time	e cause(s) and e, date end pta	d manner es ca, and due	stated. to the cau	se(s)
	To the Mospital or At within 24 hours after or To the Funeral Direct completely filled in by	Me	29b. Signature and the of cert	ifier	GIIG INTERCIOI	)		29		se number		29d. Date si	gned (Monti	, Day, Ye	ar)
	1		1/1	>	-				O.C	.M.E		AUGUST	23,	1998	
	15		30. Name and addless of per	Vi who o	ompleted cause	of deeth (Ite	m 23a) (Type,	Print)							
			21 Date 61 - 1 (14 - 11 - 2 - 1	111 Penn Street, Baltimore, Maryland 21201  (Month, Day, Year) 32 Registrar's Signature							201				
	St: Regist	ate rar	31. Date filed (Month, Day, Ye SEP 0	3 19	98	etrar's Sign	19	1	oou	61					
					-		- 4	- 1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 26938

					Certi	ificate	of	Death			Reg. No.		
Physici /Medi		Decedent's Neme (First, Middle, Last     WILLIAM HARRY MI								2. Dete of D Month		Yaar 1994	3. Time of Deeth
Examir		4e. Facility Name (If not institution, give WASHINGTON ADVENT	IST HOSPI					TAKOM	IA PA	RK	th 4c. Coun	y of Deeth GOMER	
Funeral Director			7. Ag M 2□ F	e (In yrs. lest birt 5	Yrs.	If Under 1 \ Months   C	Year		24 Hrs. Min.	8. Data of Bi (Month, D JAN . 1	rth e <i>y, Year)</i> 6, 1913	9. Birth Cou OHIC	plece (Steta or Foraig ntry) )
e Maryland	ctor	Usuel Residence of Decedant  10a. Stata MD MONTGON	1ERY	10c. City, Town									10d. Inside City Limits
h with the	Funeral Director	10e. Street end Number 208 DEARBORN AVE.				10f. Zip Co	ode 09	01			10g. Citizan of USA	Whet Cou	ntry?
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, the Madical Examinat must be notified at	by	11. Marital Status  1 Never Merried 2 Merried  3 Widowed ####vorced	12. Wes Decedant Armed Forces? 1  Yas 2  II Yes, Give Yaer or Detes:		If Y	s Deceden es, specify Yes 2/F	Cut	oan, Mexicar	gin? (Spi , Puarto	ecify Yes or N Rican, etc.)	Bi	ice - Amari eck, White ify: WH]	
I within 72 hours iene. r than "natural", the Medical Exe	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16e.	Deceder (Giva kir	nt's Usuel C	one	pation during mos	t of work	ing	16b. Kind of I	Business/Ir	dustry
f withly jiene.	ошо	Elementary/Secondary (0-12)	College (1-4or 5	AR			retire	9a).			FEDERA	L GOV	VERNMENT
S d d S	To Be C	17. Fether's Neme (First, Middle, Last) HASSIB MICHAELS		ARCHITECT						(First, Middle ARGOUR	e, Meiden Sume	me)	
nd 2 shill and 27 is m		19a. Informant's Name/Reletionship (I MICHAEL SPRAGUE (I	Type, Print) PASTOR)		_						ber, City or Town		
		20a. Method of Disposition  ###################################			ry, crame	ion (Neme tory or othe LN CE	r ple		9.	Dete -5-98	20c. Location BRENTW		
permit. Peges Department of Important: If is any Injury or once.	0	21 Signature of Funeral Service Licen	1/1/1					ess of Fecilit	HIN	ES-RINA MD 209		00 NI	EW HAMPSHI
Physician		23a. Part1. Enter the diseese, or compshock, or heart feilure. List only	-		not antar								Approximete Intervel Between Onset end Deeth
/Medical Examiner	er	Immediate Cause (Final disease or condition resulting in deeth)		Due to (or es e		ence of):		-				1	years
cate be precuted	Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last	c. Stag	Due to (or as e o	col	2 5	2	psis					weeks
e death ce the attenda	Physician/	Pert II. Other algnificant conditions of	dontributing to deeth bu	ut not resulting Ir	n the unde	erlying caus	se g	iven in Pert I		23b. Dio	l tobacco use c	ontribute	o the cause of death
es thet the de igned by the s be deteched	by Phy									1	Yee 2. No	3 ☐ Pro	bably 4 Unknow
aw requir is been s 2 should	Completed b									24a. We per	s en eutopsy formed?	a	ere eutopsy findings vaileble prior to ompletion of causa i death?
The ate h	Сош									1 🗆	Yes 2 No	1	☐ Yes 2☐ No
Physician: The this certificate ral director, pag	o Be	25. Was cese referred to medical examiner?	Hospital:				0	ther:		h (Check only			
D e	-	1 Yes 2 No  27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Injur (Month, Det		Time of njury	3□ DOA 28c. M	. Inju	unyet ork? □Yes 2□			how injury occi		fy)
	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injubuilding, etc	ury - At home, fe :: (Specify)	rm, stree	t, factory, o	ffice			28f. Location City or To	(Street and Num own, Stete)	ber or Rui	ral Route Number,
Hospit 14 hour Funera tely fills	edicai (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of liner: On the basis of end menner sta	examinetion end	, deeth o	ccurred et t stigation, in	the t	ime, date en opinion, dee	d place, th occurr	end due to the ed et the time	e cause(s) end n	nenner es	steted. to the ceuse(s)
To the within 2 To the comple	Me	29b. Signatura and title of samilier	r.Ch	ejlu,	w.c	-		286	2 (	MARGUA	29d. Date sign	ed (Month	Oey, Year)
12		30. Name and address of person who of 7350 VAN DUSE	completed cause of d		(Type, Pri	int) , N	nP	ry	AN	2	20707		
Sta Registr		31. Dete filed (Month, Dey, Year) SEP 0 3 1		ar's Signature	B.	1	100	Kel					



ate of Maryland /	Department	of Health and Mental	Hygiene
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Certificate of Death Reg. No 3. Time of Death 2. Dete of Deeth 1. Decedent's Nama (First, Middle, Last) Month **Physician** 0215 AM Angela 30, 1998 AUGUST /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, giva street and number) 4c. County of Death Examiner UNIVERSITY OF MARYLAND-SHOCK TRAUMA BALTIMORE N/A 7. Age (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dev. Yeer) 10-19-69 Birthplece (Stete or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 M 2 F Months Deys Hours 212-92-2921 28 Yrs. MO Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a Stete 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, its Medical Examinat must be northed at NIA Bathmore 1 → Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Lanuale 21216 U.S.A. 2814 W. Funeral death 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yas, Give Yaer or Dates: 14. Race - Amarican Indian, 11. Maritel Stetus Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nearly clearly and Mental Hygiene. It is the T27 is marked other than "natural", or the my or other traumate event, "\*\* Medical Fatting my or other traumate event, "\*\* Medical Fatting my or other traumate event, "\*\* Medical Fatting my or other traumate event, "\*\* Medical Fatting my or other traumate event, "\*\* Medical Fatting my or other traumate." 1 Never Merried 2 Merried Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) D. M. A, Elementery/Secondary (0-12) College (1-4or 5+) Operator machine 9th 18. Mother's Neme (First, Middle, Maldan Sumama) 17. Father's Neme (First, Middle, Last) Be Smith Charlotte Wayne 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mc Dowell Lane, Battomore, MD Charlotte Nutt 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Steta 20e. Method of Disposition 1 ☑Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata permit. Page Department of important: if any injury or page. Randallstown 4 ☐ Donetion 5 ☐ Other (Specify) mem of Funeral Service Licens 22. Name end Address of Facility E. F. H. BAST 1101 march 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset end Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examine Due to (or es e consequança of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 edical Due to (or es a consequence of): Physician/M Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 1 Yes 3 Probably 4 Unknown by 24b. Were eutopsy findings aveileble prior to complation of causa of deeth? Completed 24a. Was en eutopsy page 2 Yas 2□ No 1. Yes 2□No 25. Wes cese referred to medicel examiner? 88 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XX es 2 □ No 20 1 ☐ Inpatient 20XER/Outpatient 3 ☐ DOA 4 28e. Date of Injury Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: after death.
Director: Atter 5 Pending 1 Natural Subje 29/98 1 Yes investigation 2 Accident 6 Could not ba 3 Suicide Place of Injury - At home, farm, street, building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) factory, office Homicide (tollinswed In) 2839 Annapolis Pours 1 Cardifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

\*\*Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier edical Within 2 To the To the 29b. Signah 29c. Licensa numbar 29d. Date signed (Month, Dey, Year) nd title of certifier AUGUST 30, 1998 O.C.M.E. and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ARON LOCKE, MO 111 Penn S , MO 111 Penn Street, Baltimore, Maryland 21201

in the state of the state of

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 5:53 AM FRANCES NORMENT AVGUSE 4e Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UMBERTY OF MARYLAND MADON SYSTEM If Undar 24 Hrs. 8. Dafa of Birth (Month, Dey, Yeer) If Undar 1 Yaar 5. Social Securify Number 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 6 Sex 1□M 2XF Months Days Hours Min. 70 578 28 4035 Washington DC Oct 13, 1927 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Delaware Sussex Lewes 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 19958 126 Sweet Briar United States 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Giva Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Meritel Status Black, White, atc. 1 ☐ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 XDivorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Communication Company 12 Associate 18. Mother's Name (First, Middle, Meiden Surname) 17. Fether's Neme (First, Middle, Last) BUTLER CHARENCE A. FRANCES IHORNE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dolores M. Schrader / Friend 126 Sweet Briar, Lewes, DE 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 200 remefion 3 ☐ Removal from State Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Neme end Address of Facility CAFA Stephen D. Lohrmann P.A. Olunai 8717 Green Pastures Dr., Baltimore, MD 21286 23e. Pert1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. ACUTE HEMORRHAGIZ Immediete Ceuse (Finel disaase or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to Immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in death) Lest Due to (or as e consequence of): Dua to (or as a consequence of): 23b. Dfd tobacco use contribute to the cause of death? Pert ii. Other efanificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 3 □ Probably 4 Unknown t Yes 2 No 24b. Were eutopsy findings aveilable prior to completion of causa of death? 24e. Wes en eutopsy 1 ☐ Yes 20 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpafient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Deet 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

Department of important: If any Injury or

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Pagas 1 and 2 should be filed within 72 hours aftar on of Haath and Mental Hygiena.
Int: if item 27 is marked other than "natural", or iter
INY or other traumatic event, the Medical Examinar
INY or other traumatic event, the Medical Examina

Baltimore,

Directo

Funeral

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Completed

Be

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Physician/M daga benga the de Completed page 2 88 0

P

Certification:

edical

1 Natural

3 ☐ Suicide

29a. Certifier

2 Accidant

4 - Homicide

ig ig Affer

Division of Vital Records, P.O.

A Hospital or Attending 24 hours after death. Puneral Director: After To the Hospital of within 24 hours at To the Funeral Completely filled

Registrar

(Check only one)

5 Pending

investigation 6 Could not be

28e. Placa of Injury - At home, farm, sfreef, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

BALTMURE, MD 21201

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signeture of certifier

AU417645E9222 AUGUST 31, 1998

29d. Data signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MICHAEL EDRIENT, NO 31. Date filed (Month, Day, Year)

SEP 0 3

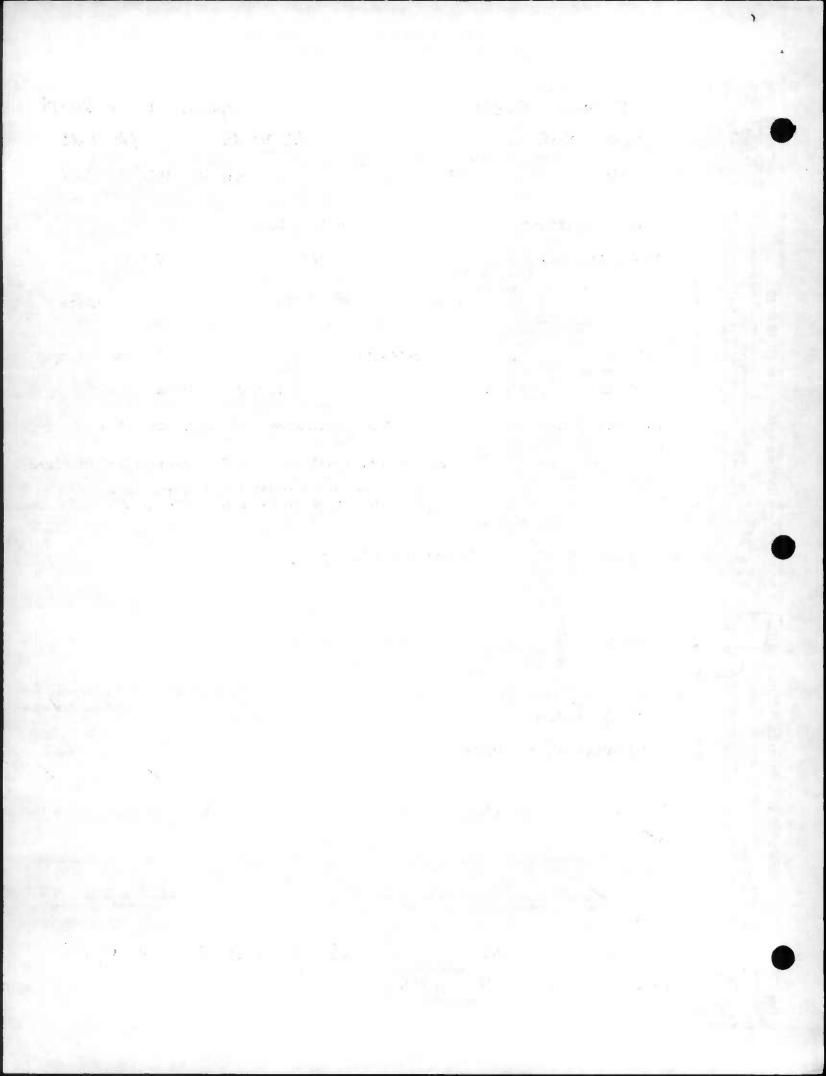
22 GREENE ST. UMMS, 32. Registrer's Signetura

29c. Licansa number

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	Decedent's Name (First, Middle, Last)		Certificate of	Dealli	2. Dete of Death	g. No.	3. Time of Death			
Physician /Medical	RICHARD	ONEAL			September		98 20:49			
Examiner	4a Facility Neme (If not institution, give s SINAT HOSP			4b. City, Town, or Los BALTIMO			Deeth ALTIMORE			
Funeral Director	5. Social Security Number 6. Sex		virthday) If Undar 1 Year Months Deys	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	1	B. Birthplace (Stata or Foreign Country) Maryland			
ehow	Usuel Residence of Decedent  10a. State  10b. County	10c. City, To	wn or Location				10d. Inside City Limits			
death with the Maryland ms 23a or 28e-f show rivel to mortified at	Maryland Baltimo	ore	Vill	La Nova	10	g. Citizen of Wh	1 ☐ Yes 2 ☒ No			
ns 23a or		Road	212	207		U.S.A				
P 2 2		12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decedent of It feet yes, specify Cub 1 ☐ Yas 2 ☒No		cify Yes or No- Rican, etc.)	14. Race Black, Specify:	Amaricen indian, Whita, atc. White			
d 2 should be filed within 72 hours at the and Mental Hygiene. 7 Is marked other than "natural", or theumatic event, in Medical Exam	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 16 College (1-4or 5+)		l of work done during most of working VOT use retired)						
be filed w tal Hygie d other the		2   I	Estimator	18. Mother's Name			unnelling			
should be nd Mental marked o umatic eve	Hiram	O'Neal		Mildre		sley				
d 2 shoth and 7 is material	19a. Informant's Name/Relationship (Ty		b. Meiling Address (Street							
ges 1 an it of Heal	Mrs. Anna O'Neal  20a. Method of Disposition  1 Suriel 2 Cremetion 3 Pa  4 Donation 5 Other (Specify)	20b. Place cemel	14 Villa Nov of Disposition (Name of ary, cremetory or other pla View Memoria	ce)		Oc. Location - C	1207 ity or Town, Stata			
Demit Per	Immediate Cause (Final disease or condition resulting in death)	Due to (or as:	Loring Bye 8728 Liber on not enter the mode of dyle by the consequence of):	cty Road ng, such as cardiac o	Randalls	town, M				
at the death certificitie be to by the articular displayers above the bornes above by the bornes above by the bornes above	resulting in death) Lest	1	e consequence of):	ven In Part I.	23b. Did tob	pacco uaa cont	ributa to the cause of death			
4 8 9		e			1 □ Ye	s 2□ No	3 Probably 4 Unknow			
he law requires that been age 2 should complete	CORONARY ARTE	RY DISEASE			24a. Wes en perform	led?	24b. Ware eutopsy findings availabla prior to completion of ceusa of death?			
delan: The conflicats rector, pa.	25. Was cese referred to medical examiner?			26. Place of Death						
After this huneral di	1 Yes 2 No	28a. Date of Injury (Month, Dey Year)	Time of Linjury M 1	ry at rk? ] Yes 2 □ No	me 5 Resider	w injury occurre				
To the Hospital or Attention 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determined	28e. Plece of Injury - At home, building, etc. (Specify)			City or Town,	Stete)				
the Hospital in 24 hours a the Funeral C spletsly filled	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	alcian: To the best of my knowled ner: On the basis of examination a end manner stated.								
To the To the Company of the Company		7	29c. Lican				(Month, Day, Year)			
. ~	0.11	mpleted cause of death (Item 23e		2402321	DP 9207	Septembe	r 01, 1998			
11	30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  DAVID PARVER, MD SINAI HOSPITAL									
10	טויי, דושאאן עבייוע	32. Registrar's Signature	PINL							

DHMH 16 Ray 6/95



CT A	DUNIOR	OWENS
	REIVE E	CMEINS

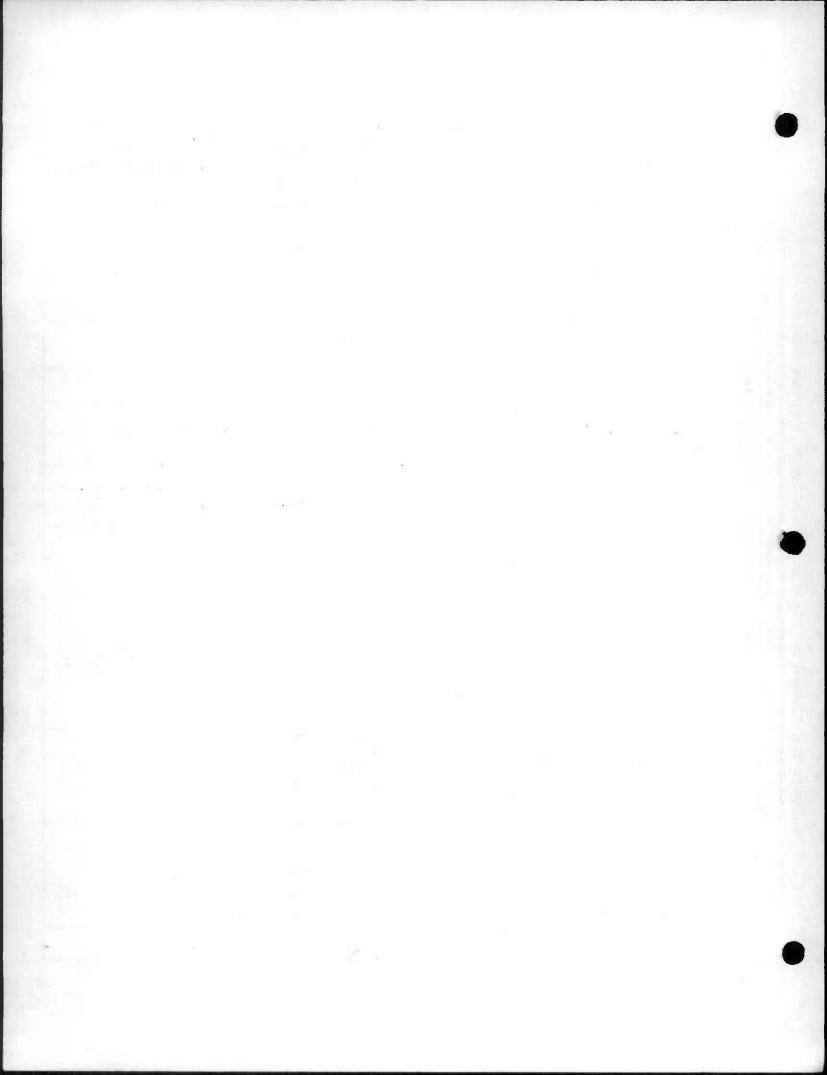
TADENICE OUTSIC	State of Maryland / Department of Health and Mental Hygiene 2	
LARENCE OWENS	Certificate of Death	

					Cert	ilicale of	Dealli		Reg. No.	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	e Owens	Sr.			2. Date of Dea Month AUG.	30, 199	3. Time of Death Year 0736 AM
	Examine		4a Facility Name (If not institution, give s 2900 BOARMAN AV	treet and number)			4b. City, Town, or BALTIM		4c. County of	of Peath
	Funeral Director		5. Social Security Number  6. Sex  2/2-20-6529  Usual Residence of Decedent	M 2□ F 7. Age (In yrs. 76	last birthday) Yrs.	If Under 1 Yea Months Day				9. Birthplace (State or Foreign South Carolina.
	Maryland		10a. State 10b. County	7	y, Town or Loca					10d. Inside City Limits  1 Yes 2 □ No
	vith the	Funeral Director	10e. Street and Number		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip Code			10g. Citizen of W	/hat Country?
	ne 23	Jera	3900 BOARMAN  11. Marital Status	2. Was Decedent Ever in U.	S. 13. W	as Decedent of	メノク Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No-	14. Race	- American Indian,
0050	urs e	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: (() (())	1[	Yes, specify Cu		to Rican, etc.)	Specify:	(, White, etc.
15-(	In 72 h	plete	15. Decedent's Educ (Specify only highest grade	completed)	16a. Decede (Give ki life. De	ent's Usual Occ ind of work don O NOT use retii	upation re during most of wo red)	rking	16b. Kind of Bus	siness/Industry
212	filed within Hygiene. Ither than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	00 -1 -		ce Wort	ker	Private	Homes
Maryland 21215-0020	should be file nd Mental Hy merked oth umetic even	To Be	17. Fathar's Name (First, Middle, Last) AvThur Owe				Eva C	me (First, Middle,	fowler	Owens
	1 end 2 sho Heelth end em 27 is mo other traum		MS Hattie Ham	pe, Print)	6116 (	011	et and Number or Ri	TIMORE, I	1 0	206
Baltimore,	permit. Peges 1 end Depertment of Heelth Important: If Item 27 any Injury or other tr ange.		20e. Method of Disposition  1 Burial 2 Cramation 3 R  Donation 5 Other (Specify)	amoval from State	lace of Disposi	ition (Name of atory or other p		9/4/98	20c. Location - (	City or Town, State  S Mills, Md
Balti	permit. Peg Depertment Important: I any Injury o		21. Signature of Funeral Service License				Russ Pullorthaue	neral He Baltimor		
	Physician /Medical		23a. Pg. 1. Enter the disease, or complication of the complex of t		h. Do not entai	the mode of d	ylng, such as cardia	c or respiratory en	rest,	Approximate Interval Between Onset and Death
	Examiner	Jec	disease or condition resulting in death) a	Antenos (	or as e consequ		4DION138	111181	16767-76	
30,		II Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	ence of):				
ox 68760,	certification and ing plant use as the t	NMedical	that initiated events resulting in death) Last	Due to (o	r as a consequ	ence of):				
0			Part II. Other significant conditions con	ributing to death but not res	ulting in the und	derlying cause	given In Part I.	23b. Dld 1	obacco use con	tribute to the cause of death?
s, P.O.	v requires that the death been signed by the etter should be deteched for	by Pmy	EALUGH, Tormin	SAC	10	1   Yes XXNo 3   Probably 4   Un				
Division of Vital Records,	_ 11 00 .	Completed by Physicia				4		twice.	an autopsy med?	24b. Were autopsy findings evailable prior to completion of cause of deeth?
Ta I	an: The	ne Co	25. Was case referred to medical				26. Place of Da	ath (Check only o	(es 2 Mo	1 Yes 2 No
> tc	Physician: this certific rel director,	0	ALC: Tes 2 NO		ER/Outpatient	3LI DOA		Home 5XX tesio		
ion	Attending P or death.  ector: After the by the funere	ation:	27. Manner of Death XX Natural 5 Pending 2 Accidant Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28c. In	juryat /ork? □Yas 2□No	28d. Describe I	now injury occurre	ed
Divis	To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this cardificate has completely fitted in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicida datermined	28e. Place of Injury - At he building, atc. (Specif	ome, farm, stree	et, factory, offic	е	28f. Location (S City or Tox	Street and Number vn, State)	er or Rural Route Number,
	Hosp 24 hou Fune letely fil	edical		Iclan: To the best of my kno er: On the basis of examina and manner stated.						
	within To the	Me	29b. Signatura and titla of certifiar	186.00			nse number C.M.E			(Month, Day, Year) 30, 1998
	n x ]	-	30. Nama and address of person who con	mpleted cause of death (Item	23a) (Type P					
	16,		Margarita Korell				t, Baltim	ore, Mar	yland 21	1201
	Stat	е	31. Data filed (Month, Day, Year)	32. Registrar's Signa	ture $\mathcal{G}$	Soon	R)			

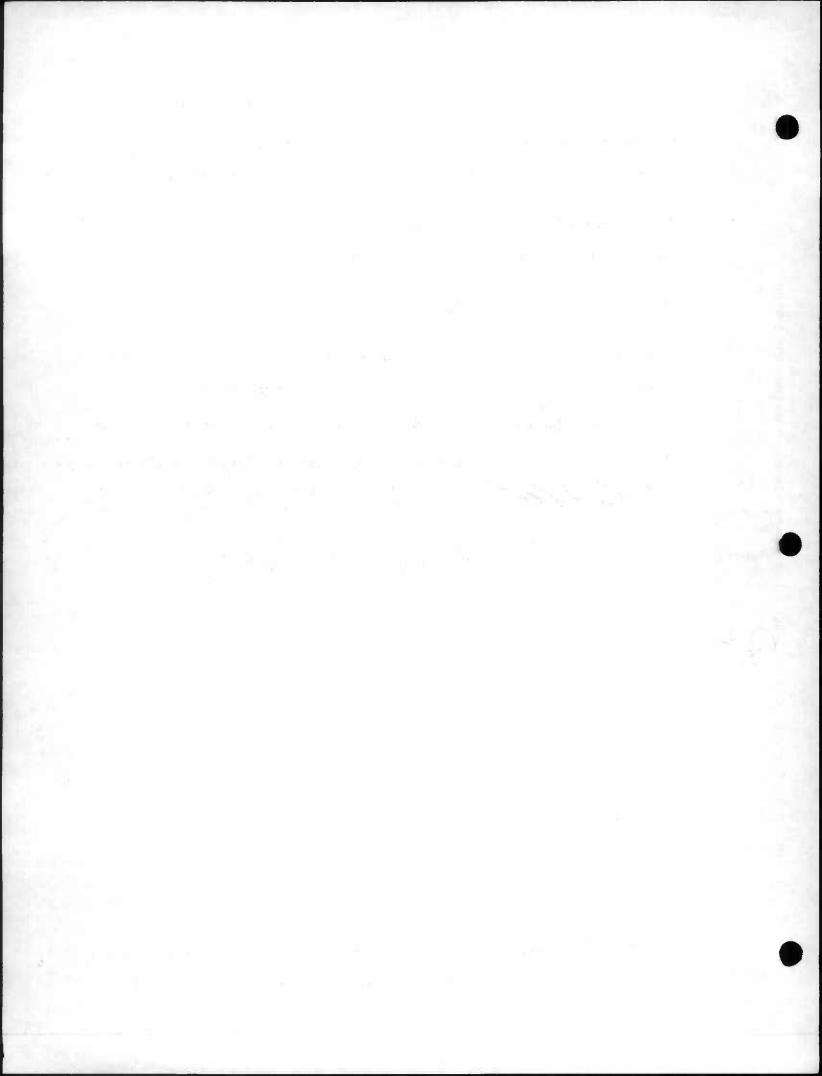
Signature Samuel pesti findesiy inter a 150 baz ili ili da la garana RE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146	D THE HOSPITAL OR ATTENDING PHYSICIAN: The law requirements are certificate be executed within	TO THE FUNERAL DIRECTOR; After this certificate has been signed as the mark and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Hygiene prior to burlat, cremation, or removal.	APORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
BOX 13	icate be exec	physician and se prior to bu	er traumat
P.0.	leath certif	attending i	ry, or oth
RECORDS,	require me	of Hearn and We	shows any injus
/ITAL	AN: The law	ificate has t	r item 23
NOF	IG PHYSICI	ter this cert	narked, o
DIVISION	OR ATTENDIN	DIRECTOR: Aft hours after dea	item 28 is n
	TO THE HOSPITAL	TO THE FUNERAL be filed within 72	IMPORTANT: If

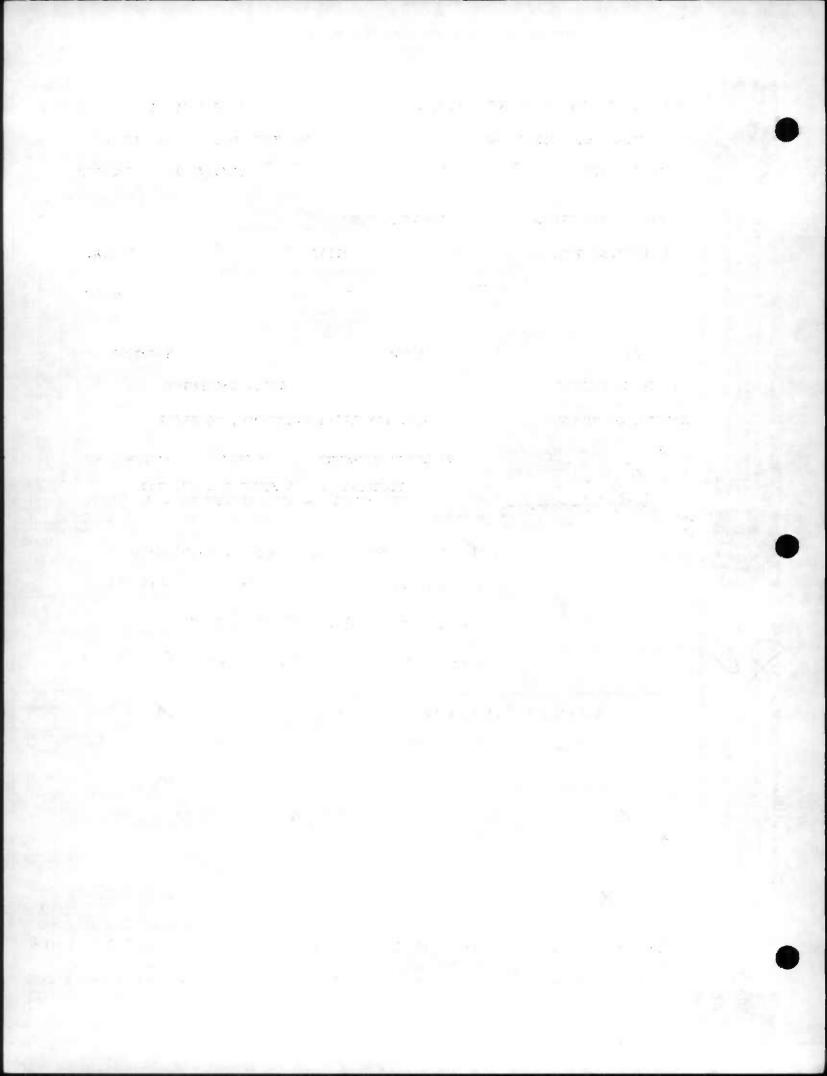
	FOR STATE REGISTRAR	STATE OF MARYI			OF HEALTH		MENTAL HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)	1101202	Dolores	01	Rourke		2. DATE OF DEATH DAY AUGUST 3(		3. TIME OF DEATH 3:40 AM		
	4. SOCIAL SECURITY NUMBER	The second second	(In yrs. last birthday)	IF UNDER	1 YEAR IF UNDER DAYS HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIF	TNPLACE (State or Foreign intry)		
	213-26-2128  9a. FACILITY NAME (If not institution, give s		67 YRS.				March 20		Maryland		
œ					TOWN OR LOCATIO	ON OF DEA	ATH	9c. COUNTY OF			
5	13 Mitchell Driv	7e		Ak	ingdon	-		Ha:	rford		
DIRECTOR	10s. STATE 10b. COUNTY		10c. CIT	ry, town o	R LOCATION				10d. INSIDE CITY LIMITS?		
	Maryland	Harford					oingdon		1 YES 2 X NO		
FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE				F WHAT COUNTRY?		
N	13 Mitchell Driv	7E	IN ILE ADMED	1 40 1		21009	C ORIGIN? (Specify Yes		States		
	1 Never Married 2 Married	FORCES? 1 YES	2 NO	1	f yes, specify Cubar	n, Maxican	, Puerto Rican, atc.)	В	ACE — American Indian, ack, White, atc.		
BY	3 € Widowed 4 □ Divorced	IF YES, GIVE WAR ON	DATES		TYES 277,40	<i>ъреспу</i> :		Sp	White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEDENT'S	Work done	CCUPATION during most of workin	a	16b. KIND OF BUS	INESS/INDUSTRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)									
MP	Unknown 17. FATHER'S NAME (First, Middle, Last)		Home	maker		150/0 1141		n Home			
		1					ME (First, Middle, Maklen :	Sumame)			
B	Hubert McCorr  19a, INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS			le Travers  Oute Number, City or Town	State 7in Code)			
5	Mr. Paul P. O'Ro	Son					oingdon, Ma		21009		
	20a. METHOD OF DISPOSITION	20	b. PLACE OF DISPO					CATION — City or			
	1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Steel (Solcify)		other place)	t. of	Jesus	9/1/	/1998 Dui	ndalk. 1	Maryland		
	21. SIGNATURE OF FUNERAL BERVICE LY	TENSEE / Y	7//	22.	NAME AND ADDRES	S OF FAC	CILITY				
	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222										
	23. PArth shart the diseases, or shock, or heert feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on  a. Multiple TO (OW AS	each line.	not enter	tha moda of dyi	ng, auch	as cardiac or respi		Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
ALC	PART II. Other aignificent condition	a contributing to death	but not reaulting	in the un	darlying ceuse (	given in i	Part i. 24s. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
2							1 TYES 2		COMPLETION DF CAUSE OF DEATH?		
MEDIC							_		1   YES 2   NO		
ä											
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER	26. PLACE OF D	EATN (Che	ck only one)				
PHYSICIAN:	1 TYES 2 THE NO	1   Inpatient 2   ER/Ou		4 🗆 Nun	sing Nome 8 D As	aldence					
	27. MANNER OF DEATN  1 Partural 8 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TII	JURY M	28c. INJURY AT WORK?	NO	28d, DEŞCRIBE NOW II	NJURY OCCURED			
D BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e, PLACE OF INJUF building, etc. (Sp	RY — At home, farm,	street, fact		,	28f. LOCATION (Street a City or Town, State)	and Number or Rui	al Route Number,		
ETE											
COMPLETED		ICIAN: To the best of my kno ER: On the basis of exeminati							e(a) and manner as stated.		
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	R				ENSE NUM			IED (Month, Day, Year)		
5	Cros M. Though	hnessy 1	UD		03	70	18	augi	upt 31,1978		
	30. NAME AND ADDRESS OF PERSON WITH		lum Tree		Bel Ai	ir, M	Maryland	21015			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG		-							
	SEP 0 3 199	8 Benera	J.	Sp	uls						



	Decedent's Name (First, Middle, La:	st)	Certii	ficate of	Dealli	2. Date of De	Reg. No.	3. Ti	im f th	
sician edical	Mark	Obenhou	se		September I 1998 4:20 1					
miner	4e. Facility Neme (If not institution, give				4b. City, Town, or		, , ,	c. County of Death		
	Mariner Health ( 5. Social Security Number 6. S			f Under 1 Year	Forest If Under 24 Hrs		Harf			
ral or		© M 2□ F 85	s. last birthday) If Under 1 Year Months Days		Hours Min.	(Month, De	19, Year) 15, 1913	9. Birthplace (S Country) Pennsy	lvania	
	10e. State 10b. County	10c. Ci	ty, Town or Locati	ion				10d. ins	ide City Limits	
ģ	Maryland Harford	Bei	l Air					1 X Yes 2 □ No		
Oire.	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?		
<u>a</u>	608 Friar Tuck I			21014			U.S.A.			
by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 No If Yes, Give Year or Detes: 1942	10	S Decedent of Hes, specify Cuba Yes 2 No	lispanlc Orlgin? (S an, Mexican, Puerl Specify:	pecify Yes or No o Ricen, etc.)		14. Race - American Indian, Biack, White, etc.  Specify: White		
eted	15. Decedent's Ed (Specify only highest gra	ucation		's Usual Occup	etion during most of word)	rking	16b. Kind of Bu	siness/Industry		
Completed	Elementary/Secondery (0-12)	College (1-4or 5+)				Killy				
	12th grade 17. Father's Neme (First, Middle, Last)		Postal	Worker		1571-A B 67-4 AL		vernment	t	
Be							, Maiden Sumam	Θ)		
10	19a. Informant's Name/Relationship (7	Type Print)	19h Malling A	ddraes (Straat	neva U	benhous		State 7in Code)		
	Beverly Baker (I				k Drive,		ir, MD.	21014		
	20a. Method of Disposition		Place of Disposition			Date		City or Town, Sta	ate	
	1 N Buriai 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State	9/4/98	Pol+im	ore, Man	L C				
	21. Signeture of Fucural Service Licen	· Ju				ryland				
1	1/1/1/1				Funeral				,	
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that ceused the deat			Phail Ro				ximate el Between	
	SHOOK, OF HEALT TANGES. LIST ONLY	one cease on each line.						Onset	and Death	
il r	Immediete Cause (Finel disease or condition	· ends	tuno	and	conny	de		>-	Time	
	resulting in death)	Due to (c	or as a consequen	nce of)	0				0	
nine.		b								
Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	Due to (d	or as a consequen	ice of):						
edical	Ceuse (Disease or injury that initieted events	c Due to (o	r es a consequen	ca of):						
	resulting in deeth) Last		·					i		
Physiclan/M		d								
ysic	Part II. Other significant conditions co	ontributing to death but not res	en in Part I.	23b. Did tobacco use contribute to the cause of dec						
						1[]	Yes 2 No	3 Probabiy	4 Unknown	
Completed by				24a. Was an autopsy performed? 24b. Were autopsy evailable prior completion of						
dm	Valority III					of death?	,			
	25. Was case referred to medical					10		1 Tes	2Q No	
o Be	examiner?	Hospital: 1 ☐ inpatient 2 ☐	FD/Outration /	Oth	er: No.			- 40		
<del> </del>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	3 DOA 28c. injur			dence 6 Other			
atio	1 Natural 5 Pending 2 Accident Investigation		Injury		k? Yes 2 □ No					
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street,	factory, office		28f. Location (	Street and Number	er or Rural Route	Number,	
						City or Town, State)				
edical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of my kno iner: On the basis of examina	wledge, death occ tion and/or investi	curred et the tin	ne, date and plece plnion, death occu	, and due to the rred at the time.	cause(s) end me date and place, e	nner es steted. and due to the ce	use(s)	
Mec	29b. Signature end title of certifier	and manner steted.		29c. Licens						
	Dans <						29d. Date signed			
	D32299 September 3,									
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dov; D 5. Down 6/5 w. MacPha;   Bel Air, MD. 20014									
	7 1		n 23a) (Type, Prin い、Mac	t)	21	A:- 1	1x 2.4"	1	, , 9	



					CCI	unicate o	Death	1		Reg. No.			
Physicial	SR. M. E	1. Decedent's Name (First, Middle, Last)  SR. M. BONAVENTURE OETGEN, R.S.M.									Dey Yeer 26, 1998 2:5		
Examine	4n Engility Name //	Town, or L	ocation of Deet	h 4c. Count	y of Deeth								
	THE VILLA	OGERS	FORGE	BALTIMORE									
Funeral Director	5. Sociel Security N 220-54-		Sex 1□ M 2以F	7. Age (In yrs. la 80		If Under 1 Ye Months Dey		er 24 Hrs. Min.	8. Date of Bir (Month, Do 02/03/	rth ey, Year) '1918	9. Birthplece (State or For Country) 8 GEORGIA		
9	Usuel Residence of												
nylan how	10a. State	10b. County		10c. City,	Town or Lo	cation					11	Od. Inside City Limits	
Mark Mark	MD  10e. Street end Nur	BALTIMO	RE	RC	DGERS	FORGE				1 ☐ Yes 2 ☐			
2 2 B	10e. Street end Number 10f. Zip Code									10g. Citizen of	Whet Coun	try?	
38 W	# 0800 BETT				U.S.	A.							
20 after death with the Maryla or Name 23s or 28e-f show miner must be notified at		ied 2□ Married	Armed Fo	12. Wes Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 2X No If Yes, Give  13. Wes Decedent of If Yes, specify Cul					pecify Yes or No Ricen, etc.)	Bla			
1 21215-0020 ed within 72 hours at ver then "netural", or it, the Medical Exam Completed by F		4 Divorced	Year or Di			ILITES ZALIN	ю зресп	у.		Specify: WHITE			
	(Cno.	15. Decedent's E	ducation		16e. Deced	lent's Usual Occ	cupation	ant of word	kina	16b. Kind of Business/Industry			
E	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)	life. L	kind of work do OO NOT use ret	ired)	USE OF WORK	wig	ny .			
to be and	12	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4							HOSP	ITAL		
D High	17. Fether's Neme	(First, Middle, Last	)				18. Mot	her's Nem	e (First, Middle	, Maiden Surne	Maiden Surneme)		
to de de de de de de de de de de de de de	H. GLENN	OETGEN						HELE	N McCOF	RMICK			
Maryland d 2 should be fish th and Mental Hy T is marked oth traumatic event	19e. Informant's Na SISTERS C		(Type, Print)			g Address (Stre				per, City or Town	, State, Zip	Code)	
Daring Tags	20e. Method of Disp	position		sition (Neme of			Date	20c. Location - City or Town, 5		wn. Stete			
Baltimore semil. Pages 1 Department of He reportant: if lan my injury or oth ance.	1 🗷 Burial 2   4 ☐ Donetien	Cremetion 3 5 Other (Speci	fy)	State	netery, cren	CEMETE	olece)	8	/28/98	WOODL			
Baltim permit. Pa Department important any injury ance.	21. Signaturo et Fu	a Service Lice	ME, INC		28								
	and Part Enters	diseese, or con feilure. List only	plicetions that c	eused the death.							5 212	Approximete	
Physician /Medical Examiner	Immediate Ceuse disease or condition resulting in death)  Sequentially list condition resulting in death	n	ө b	REFRAC-		cok(					1		
o en da la	Sequentially list co if eny, leading to in cause. Enter Unde Ceuse (Disease or	nmediate orlying	ISCHEMIC CARDIO MYOPATHY										
760	that inflieted events		C. Due to (or es e consequence of):										
8	resulting in death) I	Lest	CORONARY ARTERIOSCLENOSIS										
XX II			d	Colle	NAI	(	4117	713	1020	1 2 110 -	12		
m A	5								001 001	landi a company			
	ALL STATES		contributing to death but not resulting in the underlying ceuse give  No VASCULAR ACCOR					rt I.	1 🗆	contribute to the cause of death?  3 Probably 4 Unknown			
	outbleted by	٥	STEO	Pono	212					s en eutopsy ormed?	eve	ere eutopsy findings eilable prior to mpletion of ceuse deeth?	
The law	Ē								4.0	V			
E 2 2 2									10	Yes 2 200	11	Yes 2□ No	
Vita Senti	25. Wes case refer examiner?	,	Hospital:				0.1		th (Check only				
Phys and a side	1 ☐ Yes 2		1 1 1		R/Outpetier	I BLI DOA	4/4	Nursing H		idence 6 Ot		y)	
sion and and and and and and and and and an	27. Manner of Deet  1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigation	28e. Date of Injury (Month, Dey Year)  28b. Time of lnjury  28c. Injury et Work?						28d. Describe	how injury occu	rred		
Divis	3 ☐ Suicide 4 ☐ Homicide	6 Could not to determined	28e. Piece	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location City or To	(Street end Num own, State)	ber or Rura	l Route Number,	
	29a. Certifier (Check only one)	Certifying Pl	minar: On the ba	best of my knowl asis of examinetic ner steted.	ledge, death on end/or inv	occurred et the restigation, in m	time, dete	end plece, eeth occur	, end due to the rred et the time	ceuse(s) end m , date end piece	enner es si , end due to	teted. the ceuse(s)	
To the To the	29b. Saneture end	title of certifier	r	0	10 ~		ense numbe		6	29d. Date sign		Dey, Year) 6-1998	
	Joseph	D. No	0-	gels			וסע	ا ۱ ر		AUGU.	, 4	0-1110	
2	30. Nagle end eddr	ess of person who	completed ceus	e of deeth (Item :	23e) (Type,	Print)	Paul	01	acs a	111	016	4021202	
	102EhH ]		ANANG	ELO M	-12,	301 27	. raul	- 567	1-6-13	1) LTIM	1 2 1	40 71707	
State	31. Dete filed (Moni	th, Dey, Year)	32. R	egistrar's Signatu	re								



State of Maryland / Department of Health and Mental Hygiene | R Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daeth 3. Time of Deeth Month 3:15 pm **Physician** POLINIG ROGER L. /Medical 4a Fecility Name (If not Institution, give streat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner University of Md. Medical Center Baltimore If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) If Undar 1 Yaar 9. Birthplace (Stata or Foraign Country)
On10 6. Sex **Funeral** 1**∑**M 2□ F Months Days 64 Yrs. Dec.21,1933 Director 801-28-4640 Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 21 No Director Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 34 High Road 21919 Usa death Funeral 12. Was Decedent Ever in U,S. Armed Forces? ► Table 2 □ No 1/ Yas, Giva Year or Datas: Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Maritel Status Pages 1 and 2 should be filed within 72 hours after nen of Health and Mental Hygiene. In: If item 27 Is marked other than "natural", or fleating or other traumatic event, its Medical Establing iny or other traumatic event, its Medical Establing. 1 Navar Marriad 2 Married 1 ☐ Yas 2 🖾 No Specify: Specify: White by 3 ☐ Widowad 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) Computer Systems Analyst Government 18. Mothar's Nama (First, Middla, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Mildred Hanby Delas C. Poling 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 34 High Road, Earleville, MD 21919 Mrs. Joan Poling Baltimore. 20b. Placa of Disposition (Nama of cematary, crametory or other placa) Deta 20c. Location - City or Town, Stata 20a. Method of Disposition permit. Page Department of Important: If any injury or once. Greenmount Crematory 9/3/98 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funeral Service Licenses Mitchell-Wiedefeld Home, Inc. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or haert failure. List only one cause on each line. 21212 Approximata Interval Between Onset and Deeth **Physician** FAILURE Immadiate Ceuse (Finel disaase or condition resulting In daath) CARDIAC WK /Medical Examine Dua to (or as a consequence of); MYOCAPOIAL Sequantially list conditions, if any, leeding to immediate cause. Entar Undarlying Causa (Disaase or Injury that Initieted events rasulting in death) Last Due to (or es a consequence of): ATHEROSCHEROSIS Dua to (or as a consequence of) Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. requires that the 1 2 No 3 Probably 4 Unknown Inna operative 2q De d 24b. Were autopsy findings evailable prior to 24e. Wes an autopsy performad? Completed complation of causa of daath? page 2 1 ☐ Yas 2 ☐ No certificate Hospital or Attending Physician: director 25. Was case rafarred to medical axaminar? 26. Pleca of Deeth (Check only ona) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Vas 2 No 2 this funeral 27. Manner of Deeth 1 Natural 2 Naccidant 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: After 5 Panding investigation after death. 1 ☐ Yas 2 ☐ No 3 Sulcida 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) ∠ 4 ☐ Homicide 24 hours edicai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29c. Licensa numbar 29d. Data signad (Month, Dey, Year) 29b. Signature and titla of certifier Resident ise of deeth (Itam 230) (Type, Print) 22 South Greene Greet, Beltmore, , umms Wellen 32 Régistrar's Signatura 31. Date filad (Month, Day, Year) State Pener SEP 0 3 1998

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State of Maryland / Department of Health and Mental Hygiene

mend:	#17	Per	FH	Film	G763	9-3-98RC

Certificate of Death

If Under 1 Year Months Days

10f. Zip Code

Months

3. Time of Death

Physician /Medical Examiner

the Maryland

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

poemit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Department if flem 27 Is marked other than "natural; or fleme 23e or improvent: If flem 27 Is marked other than "natural; or other traumatic event, the Medical Examine must be any Injury or other traumatic event, the Medical Examine must be a

**Physician** 

/Medical

Examiner

physician and the bunal-transit

for use as

signed by the a

should

i certificate has l

funeral director,

this

After

after death Director: A

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

L

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Hospital or Attending Physician:

Examiner

Physician/Medicai

g

Completed

Be

Certification: To

edicai

Baltimore, Maryland 21215-0020

Virginia Hobbs Planter 4a Facility Name (If not institution, give street and number)

1 M 20 F

2. Date of Deeth Month August 25,

1998 2130 4c. County of Death

1510 MOSHER STREET Apt. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex

4b. City, Town, or Location of Death BALTIMORE

N/A

**Funeral** 212-34-1577 Director

Directo

Funeral

p

Completed

Be

Usual Residence of Decedent 10e State 10b. County

1. Decedent's Name (First, Middle, Last)

10c. City. Town or Location

64

If Under 24 Hrs. 8. Date of Birth Hours Min. Jul 15, 1934

9. Birthplece (State or Foreign Country) SC .

10d. Inside City Limits

10e. Street and Number

**Baltimore** 

Yes 2 No

1510 Mosher Street Apt. 7F

21217

10g. Citizen of What Country? 14. Race - American Indian,

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No Specify:

Black, White, etc. Specify: **Black** 

Housekeeping

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

12th 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

Leonard Pl

WILLIAM HEATH

Bessie Walker

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1311 Slater Road Baltimore, Md 21225

Vernita Beatty (Daughter)

20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State

1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie

Mt. Zion Cemetery 22. Name and Address of Facility

8/31/98 Lansdowne, Md. Caple Funeral Service

5502 Winner Avenue Baltimore, Md 21215 show that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, ceuse on each line.

Atheroschiote Cardiovascular Dialas

Approximate Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting In deeth)

Due to (or as e consequence of):

Due to (or as e consequence of)

Due to (or as e consequenca of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Minknown

habetes mellitus

24e. Was an eutopsy performed?

24b. Were autopsy findings available prior to completion of ceuse of death?

1 Yes

26. Place of Death (Check only one)

1 □ Yes 2 □ No

25. Was cese referred to medical TXXYes 2□ No

1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of tnjury (Month, Dey Year) 5 Pending

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

Wedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Dey, Year) August 26, 1998

allumin

Investigation

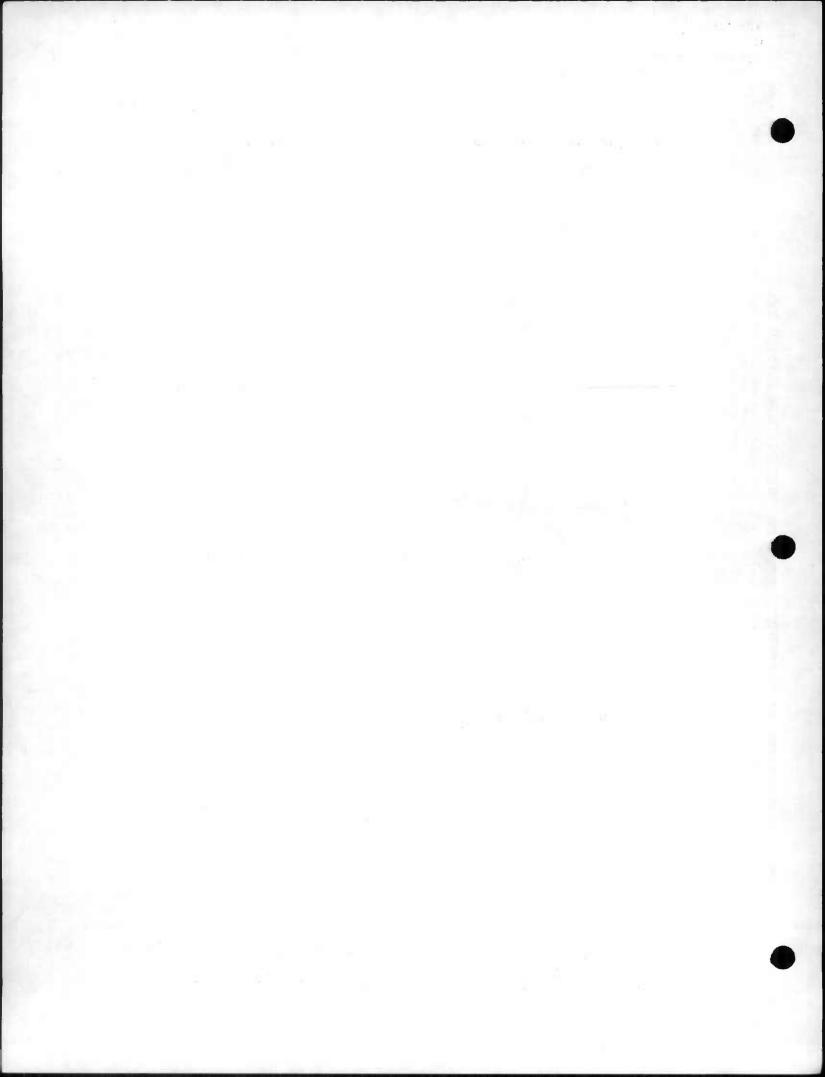
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

ennis 31. Dete filed (Month, Dey, Yeer) SEP 0 3 1998

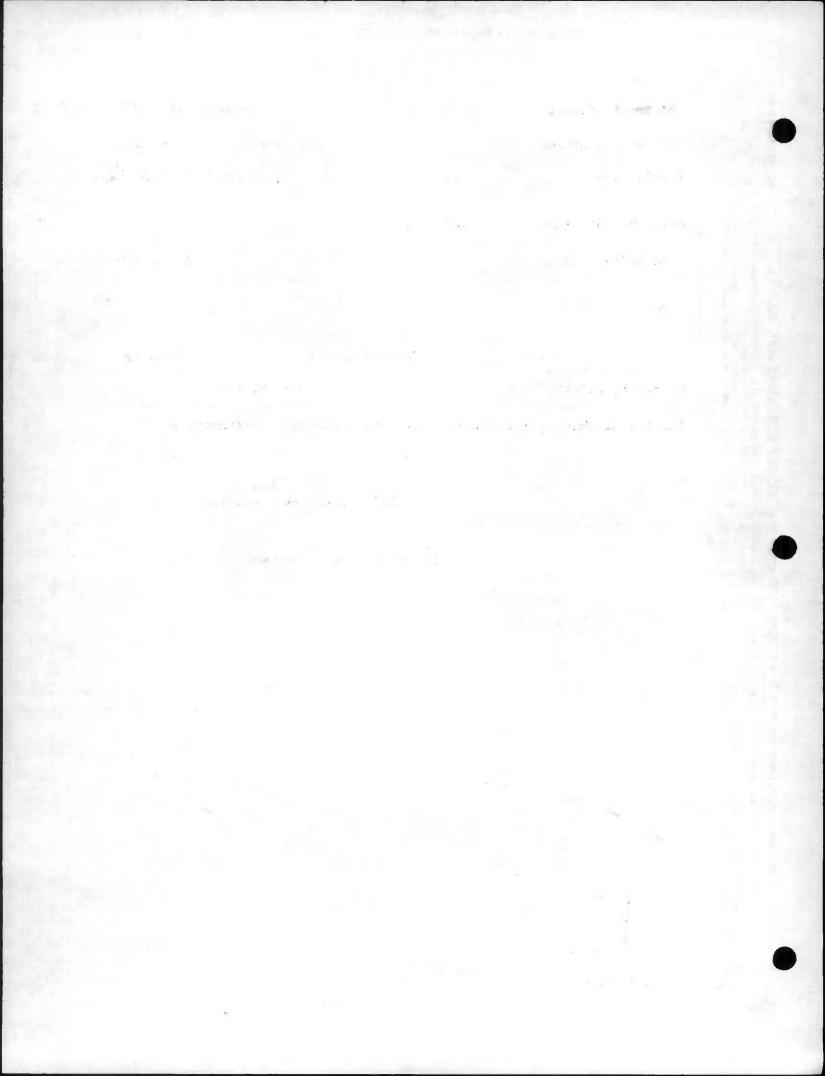
32. Registrar's Signature

ME

State Registrar

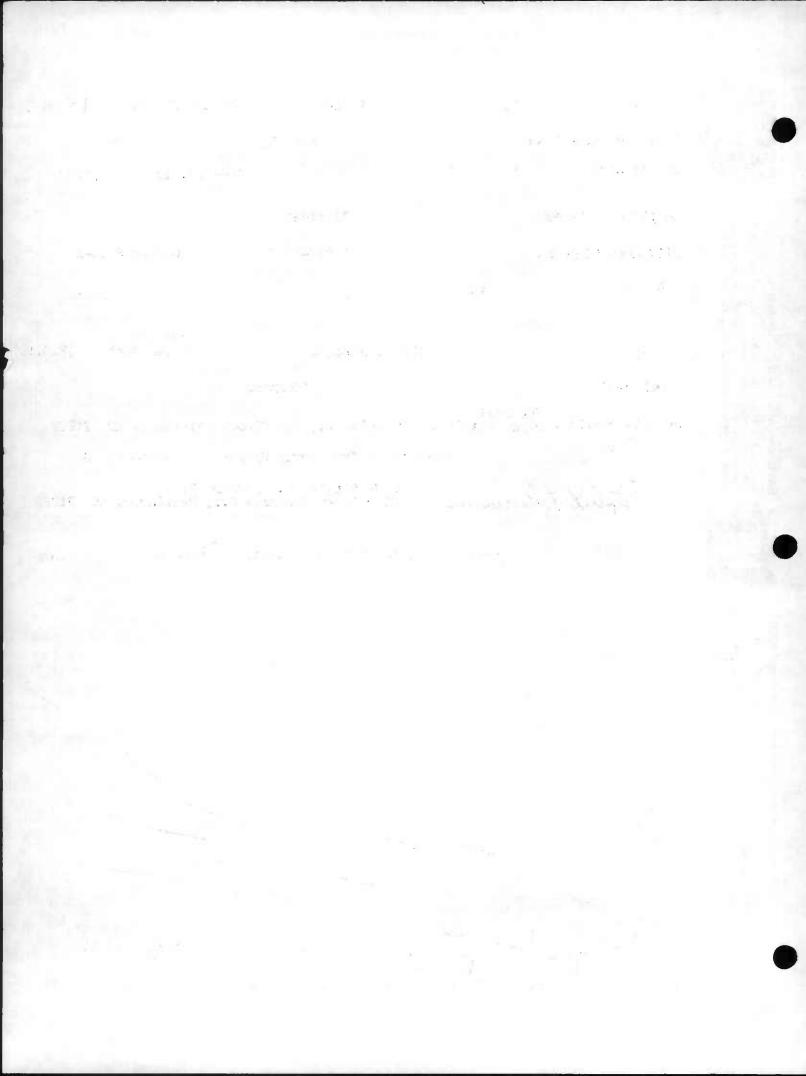


	Item	#20a.b.c. per	FH G763 9/		aryland /	Certific		Health and N Death		Reg. No.	26	948	
	Physician	1. Decedent's Name (First, Middle, Last)								Death Dey Year		3. Time of Death 4:00 AM	
	/Medical	al Betty Peters								August 28, 1998 Location of Death 4c. County of Death			
	Examiner	1210 Wedde1 Avenue Balt:  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under							re Baltimore			lace (State or Foreign	
Di	irector	219-16-796 Usual Residence of De	8	IM 200 F	73	Yrs.			April	28,1925		aryland	
yland	how.		0b. County	. 6	10c. City, Tov	wn or Location					1	Od. Inside City Limits	
e Ma	or 28a-f a		Baltimor	e	Baltimo		Zip Code					1 ☐ Yes 2 🙀 No	
with th	Dire	10e. Street end Number	- 70	10g. Citizen of W									
5-0020 72 hours after death with the Maryland	'natural', or frame 23a or 28a-f ahow edical Experient must be notified at letted by Funeral Director	1210 Wedde 11. Maritel Status 1 Never Married 3 Widowed 4	2 Married	12. Wes Decedent Armed Forces 1 Yes 2 X If Yes, Give Yeer or Detes:		If Yes,	cedent of I	227 Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		- Americ , White,	merican Indien, /hite, etc.	
21215-0020 od within 72 hours affore.	-natur morral	(Specify Elementary/Seconda	5. Decedent's Educ only highest grade ary (0-12)	cation	5+)		work done Tuse retire	during most of work	king	16b. Kind of Business/Industry			
d 2 Hydie	2 5 4												
arylan should be	D . III												
- N W		19a. Informent's Name	e/Reletionship (Ty)	pe, Print)	19	b. Meiling Add	ress (Stree	t and Number or Ru	ral Route Numb	er, City or Town, S	State, Zip	Code)	
	item 27 other tr	Bernard L.		- brothe	-	502 Whi		enue, Ba	1timore	, MD 21	214	um State	
	Important: If ite any injury or of pace.	1 D Burial 2 C 4 Donation 5	Cremation 3 □R □ Other (Specify)		cemete	ery, crematory dlawn Ce	orotherpla metery		8/30/98	Baltimore	Md.		
Bal permit	any in	22. Name and Address of Facility Loudon Park Funeral Hor 3620 Wikens Ave. Baltimore, MD 21229  23 Part Enter to disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure that only one cause on each line.											
Phy	sician	23a Part1 Enter to shock, or healt to	disease or compli	cations that cause le ceuse on each l	d the death. Do	not enter the	node of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Deeth	
/M	edical miner	Immediate Cause (Fir disease or condition resulting in death)	nal		Pa	more	which	Concer		7.5		12 mo	
	- 10 m	resulting in death)			Due to (or as e	consequence	of):						
Decuted	end I-trensit Xamin	Sequentially list condi	itions,	)	Due to (or as a	consequence	of):		2 1				
68760, ificete be axecuted	physician end the buriel-trensit dical Examiner	t if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.  That initiated events Due to (or es e consequence of):											
Box 6													
. 100	e atte	Part tl. Other stgnifica	int conditions con	tributing to death b	out not resulting	in the underlyi	ng cause gi	iven in Part I.	23b. Did	tobacco use con	tribute to	the cause of death?	
P. P. O.	igned by the attending be dateched for use es by Physician/Me								13	Yes 2□ No	3 ☐ Prol	bably 4 Unknown	
Vital Records,	2 should									an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion ot cause deeth?	
<u>a</u>	page . page								10	Yes 2 No	1 [	Yes 2□ No	
of Vita Physician:	rector, page Co	25. Was case referred examiner?	Н	lospital:			01	26. Place of Dea			. (0		
on of	at Director: After this cled in by the funeral director Certification: To	27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	1 ☐ Inpati 28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c. Inju	4   Nursing n	ome 5 Aes 28d Describe	idence 6 □Othe how injury occurre		y)	
P P	od in by the Certificat	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of In building, e	jury - At home, t c. (Specify)	farm, street, fa	ctory, office		28f. Location ( City or To	(Street and Numbe wn, State)	or Aure	il Route Number,	
Me Hospital	To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier 1[ (Check onl) 2[ one)	☑ Certifying Phys ☐ Medical Examir	lcian: To the best ner: On the besis of end manner si	of exemination e	ge, death occur nd/or investige	red at the t tion, In my	ime, date and place opinion, deeth occur	, and due to the rred at the time,	cause(s) and mar date and place, a	ner as s nd due to	tated. the ceuse(s)	
To th	Comp	29b. Signature and title	e of certifier		M.D.			se number ) 45390	2	29d. Date signed			
	9	30. Neme end eddress	of person who co	mpleted cause of CS3		(Type, Print)	DA.	+200,	BALTY	wore,	nD	21237	
	State Registrar	31. Date filed (Month,	EP 0 3 19		rar's Signature	<b>5</b> .	Spar	ks	19				



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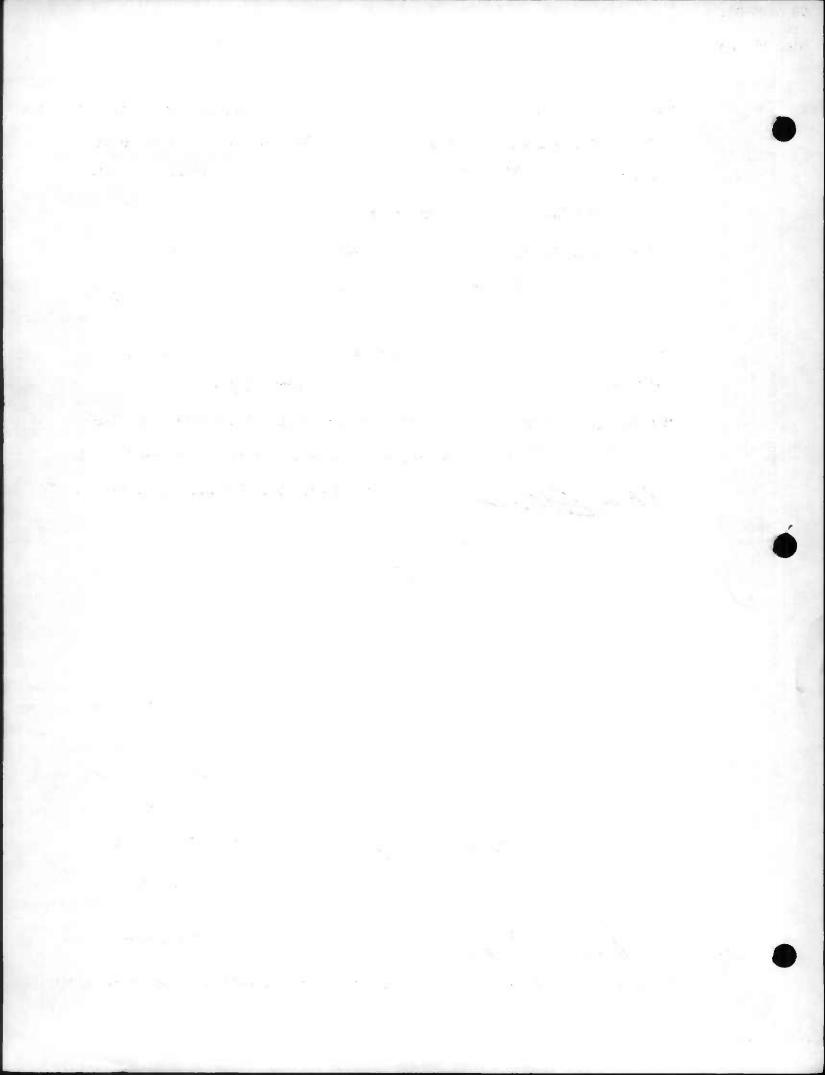
				Cer	tifica	te of	Death		Reg. No.			
Physician	1. Decedent's Name (First, Middle, Last)  Doris  E.			Poehnert					b 29, 1	998	3. Time of Deeth	
/Medical Examiner	4e Fecility Neme (If not institution, giv							Augus  Location of Deeth			10	
LXAIIIIIIEI	6137 Hunt Club Ro	1.					Elkridge	9	]	Howar	d	
neral ector	5. Social Security Number 6. S 214 14 4175	ex 7. Ag	e (In yrs. la:	st birthdey) Yrs.	If Unde Months	Deys	If Under 24 Hrs Hours Min		h y, Yeer) 4,1921		place (Stete or Foreign htry) Yland	
	Usuel Residence of Decedent  10e. State 10b. County		10c City	Town or Lo	cation					1	Od. Inside City Limits	
thygiane. ther than "natural", or items 23e or 28e-f show and, the Medical Example from the northes at completed by Funeral Director	Maryland Howar				1 ☐ Yes 2 XNo							
Funeral Director	10e. Street end Number 6137 Hunt Club Ro	1.			10f. Z	Code 210	75-5510		10g. Citizen of Unite		,	
by	11. Merital Stetus  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 22 If Yes, Give Year or Detes:	If Yes, specify Cuben, Mexicen, Po					? (Specify Yes or No- uerto Rican, etc.)  14. Rece- Bleck, Specify:			American Indian, White, etc. White	
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-			16e. Decedent's Usuel Occupetion (Give kind of work done during most of life. DO NOT use retired)  Office Manager					16b. Kind of B Federa Govern			
ပိ	17. Fether's Name (First, Middle, Last,	)	1	0111	JC III	inage		me (First, Middle,			(1.00.1.	
To Be Compi	(Unknown)						(Unknow					
-	19e. Informent's Name/Relationship (	19e. Informent's Name/Relationshlp ( <i>Type, Print</i> ) Personal 19b. Meiling Addre							er, City or Town	State, Zip	Code)	
	John B. Powell / Representative. 100 Light St., 3rd Floor, Baltimore, M  20e. Method of Disposition  20b. Plece of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City  20c. Location - City  20c. Method of Disposition  20c. Location - City  20c. Location - City  20c. Method of Disposition (Name of cemetery, cremetory or other place)  20c. Location - City										or Town, State	
Department of Important: If he any injury or o gines.	4 Donetion 5 Other (Specifical Service Licer				ess of Fecility	2/ 30	Datei	HOLE,	PID			
	CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimo										re, MD 21286	
n al neu	Immediate Cause (Final disease or condition resulting in death)  e. Atheroscleratic Cardiovaradan Disease ye Due to (or es e consequence of):										Onset end Death  Years	
Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Undertying Ceuse (Diseese or injury that initiated events resulting in death) Lest	c	Due to (or a	es e conseq es e conseq								
clan	Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.  23b. Did tobacco use contribute to the cause											
/ Physician/N	Pert II. Other significent conditions of	ven in Pert I.	23b. Did tobacco use contribute to the cause of 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ U									
pleted by								24e. Wes en eutopsy performed? 24b. Were eutops eveilable pric completion of deeth?				
E O	Marie Harrison							10	Yes 2 No	1 [	□Yes 2□ No	
	25. Wes cese referred to medical exemined							eth (Check only	one			
his cartificata has been si al director, page 2 should To Be Completed	1 Nes 2 No	Hospital: 1   Inpatie		R/Outpetler		/OA		Home 5 Presi		-	fy)	
Certification:	27. Manner of Death  1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		y Year)	28b. Time of injury	М	28c. Inju Wo 1 [	ry et rk? I Yes 2 □ No		e how injury occurred			
Certifi	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of Inj	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location ( City or To	orreet and Num wn, Stete)	per or Hun	el Route Number,	
Medical		ysician: To the best niner: On the basis o and menner st	f examinetic									
Ž	296. Signeture end title of certifier	se number		29d. Date sign	ed (Month,	Dey, Year)						
	30 Name and address of source with	completed seven of	Leath (Item)	23a) (Time	Print)	D3	1473	, Sept 2/98				
/	20. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)  PATTINGEA. TOTE, MN 4565 Hembole Corre Way Ellicot								coffcet	~ m	0 21042	
State	31. Date filed (Month Day Mar) 99		er's Signatu	- 1-1	190	600		-0		1		



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of Maryland / Department of Health and Mental Hygiene	0	y	J	U

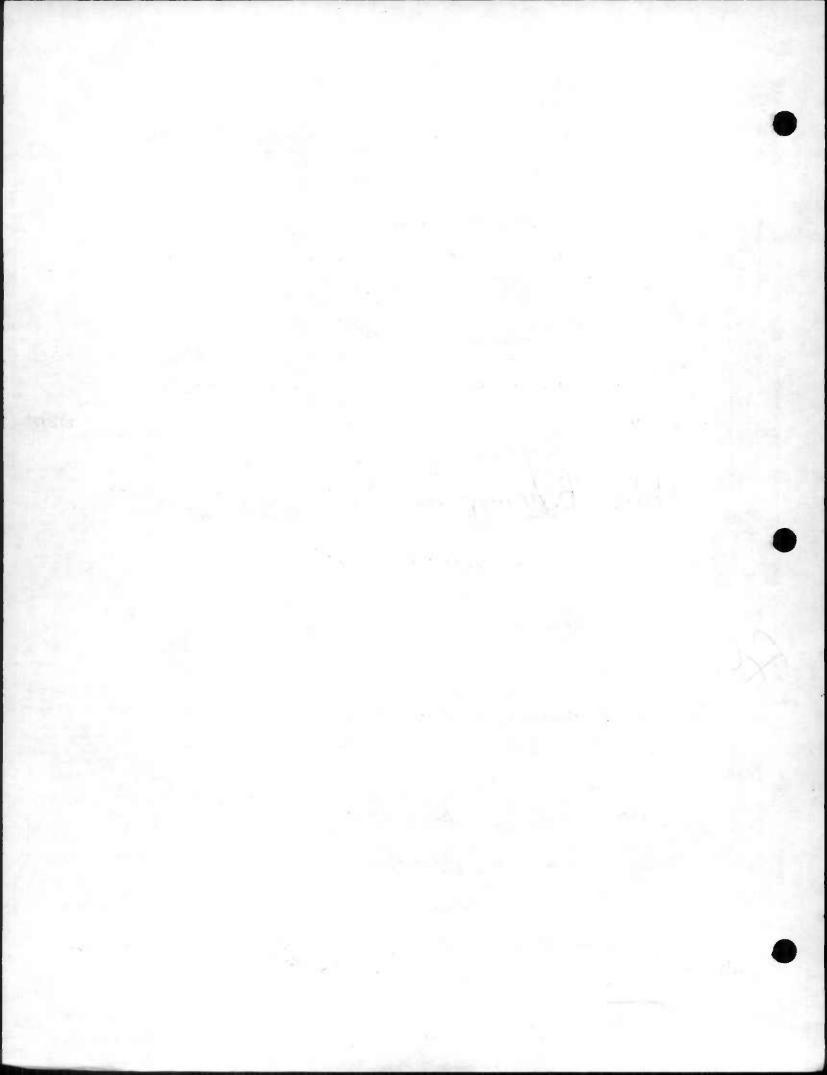
						C	ertifica	ate of	Death			Reg. No.			
		1. Decedent's Nan	ne (First, Middle, L	ast)							2. Date of D	eeth			3. Time of Death
Phys /Me	ician dical	Minh	Phuor						Month Day Yea August 31 199			11:08 A.M			
Exam		4a Fecility Neme	(If not institution, gi	ive street end number,				4b. City, Tow				County of			
		Difficul	t Run ar	ea of the	Poton	nac F			Great			Mo	ontga	mery	7
Funer Directo		5. Social Security f 577-04- Usual Residence of	1598	Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. I	est birtho	Month	ler 1 Year s Days		4 Hrs. Min.	8. Dete of B (Month, D 12/1	irth ey, Year) 6/77		. Birthpli	ace (Stete or Foreign
and **		10a. State	10b. County		10c. City	, Town o	r Location							10	Od. Inside City Limits
se-f she	the Mery	VA	Fairfa	x Great			Falls								1 ☐ Yes 2X No
ath with th	Funeral Director	10e. Street and Nu 10852 M	onticell			2	Zip Code 2066				US				
If I I I I I I I I I I I I I I I I I I	by	11. Marital Status  1 X Never Married 2 Married  3 Widowed 4 Divorced		12. Was Decedent Armed Forces' 1  Yes 2  It Yes, Give Year or Dates:	?	S.	13. Was Decedent of It Yes, specify Co		nt of Hispanic Origin? (Specify Cuban, Mexican, Puerto Ricar ¶No Specify:			0-	14. Raca - Black, Specify:	America White, e	etc.
72 hours naturel',	eted	(Spe	15. Decedent's E	ducetion rade completed)	cetion 16a. Decedent			uai Occu vork done	pation during most o	of workii	ng	16b. Ki	nd of Busin	ness/Ind	ustry
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filed Hygin		17. Father's Name	(First, Middle, Las	t)			ruden	L	18. Mother	s Name	me (First, Middle, Maiden Sumame)				-
d 2 should be file th end Mantal Hy 7 le marked other treumatic event	To Be	Mui Phu				Loar	n Ng	uyen							
d 2 should the end Man	-	19a. informant's N	19b. M	lailing Addre	ss (Stree	t end Number			ber, City o	r Town, Sta	ate, Zip	Code)			
- 5 # C +		Mui Phu	iong - Fa	ther		1085	2 Mon	tice	llo Ct.	., G	reat F	alls	, VA	220	066
SIZE		20a. Method of Dis		Removal from State	moval from State 20b. Place of cemete Metro					9/	Date 3/98	20c. Location - City or Town, State Alexandria, VA			
permit. Peg Department Important: i	permit. Pege Department of Important: if any Injury or once.	21. Signature of Fr			22. Name	and Addr	ess of Facility						ndon, VA		
		In	10 /10	nplications thet cause y one cause on each I										-	Approximate
ceta be executed physician and stra buriel-transit	Examiner	disease or condition resulting in death)  Sequentially list or if eny, leeding to inceuse. Enter Und. Cause (Disease of that initiated event		s a consequence of):											
death cartificeta be exe ettending physician a od for usa as tha buriel-	Physician/Medical	that initiated event resulting in deeth)	s Last	d	Due to (or as a consequence of):										
0 0	SC	Part II. Other signi	ficent conditions	contributing to death t	tying ceuse given in Part I.			23b. Did tobacco use contribute to the cause of				the cause of death?			
res that the designed by the e	by Phy										1	Yes 2	PNo 3	☐ Prob	ably 4 Unknown
requi been s	Completed t							L		ŀ		s an eutop formed?	osy 2	con	re autopsy tindings illeble prior to npletion of ceuse deeth?
Tha law ata hes page 2	E										100	Yes 2	□No	12	Yes 2□ No
	Be	25. Was cese rete	rred to medicel						26. Place	of Death	(Check only	one)			
Phys raidi	2	examiner? 1 X Yes 2 2		Hospital: 1 ☐ inpati 28a. Date of Inju (Month, De	ury	ER/Outpa 28b. Tim Inju	ne of	DOA OI			Home 5 ☐ Residence 6 X Other (Specify)at SCEN			at scene	
l or Attending after death. Director: Aftal d in by the funa	catlo	1 ☐ Naturel 2 ☐ Accident 3 ☐ Suicide	investigation	on 8/29/	98	193	OpM	1[	Yes 2 TN	Yes 2 PNo Sulf		e Cf drawned tion (Street end Number or Rurel Route Number,			I Poute Number
To the Hospital or Attend within 24 hours after death To the Funerel Director: / completely filled in by the f	Certification:	4 ☐ Homicide	determined	building, e	28e. Place of Injury - At home, tarm, sweet, factory, office building, etc. (Specify)  River						City or To	own, State	Poton	nac	River
Hosp 24 hou Fune Fune	edical	29a. Certifier (Check only one)		hysicien: To the best miner: On the basis of	t examinat										
ithin Smple	Mec	29b. Signature and	title of certifier	and menner st	tated.		12	9c. Licen	se number	-		29d. Dat	le signed (	Month, I	Dev. Year)
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)		De neus	J. Ch	completed ceuse of a	death (Item	23a) (Ty		Penn	Street	. B	altimo	re. N	Marvl	and	21201
5	tate	31. Dete filed (Mor	oth Day, Year)		rar's Signal	ture	- /	-		,					
Regis	strar	SEL	U 3 1338	Mary 18		J.	has	11							



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Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** PINKSTON Jr. AUGUST 29 0825 WILLIAM /Medical 4a Facility Nama (If not institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Deeth Examiner NOTTH WEST HOSPITAL BALTIMORE CENTER KANDALLSTOLUN If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Min 70 Yrs. 215-38-9427 Director JUNE 4, 1928 VIRGINIA Usual Residence of Deceden 10a. State 10b. County r 28a-f show 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or any Injury or other traumatic event, the Medical Examples must be page. 3637 FOREST GARDEN AVENUE 21207 Funeral U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 M Yes, 2 □ No JULY If Yes, Give Year or Dates: JULY 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 1946 31,1966 11. Marital Status 14. Race - American Indien, Bleck, Whita, atc. 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 Specify: NEGRO 2 3 Widowed 4 Divorced JULY Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SUPERVISOR/OPERATION ANALYST POST OFFICE N/A ONE YEAR 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fether's Neme (First, Middle, Last) Be WILLIAM PINKSTON, SR BEATRICE HOBSON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS PINKSTON / WIFE 20b. Place of Disposition (Name of cemetery, cremetory or other place) SEPT. 4Dete 19 80c. Location - City or Town, State 21207 20a. Method of Disposition Burial 2 Cremetion 3 Regul GARRISON FOREST VETERANS CEM. BALTO, CO, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Fornature of Funerel Service Figens 22. Name and Address of Fecility CALVIN B. SCRUGGS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that realized the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on machining PRESTON ST. BALTO, MD. 21213 Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Upper GI Hemorrhage Examiner Due to (or es a consequence of): Esophageal CANCER Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last and Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. Records, P.O. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Antero Cateral HII þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitat: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascriba how injury occurred Attanding Netural 2 Accident 5 Pending investigation after death. Director: Aft 1 Yes 2 No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours after d To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) To the To the To the I 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oneus MO DZZ751 August 29, 1998 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 1241 Hospital Center ED, Randallstown, Nd. Owens MD Northwest USAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 0 3 1998 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Data of Daath 3. Tima of Death Month BLANCHE KUSSELL 15:08 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Nama (If not institution, giva street and number) BALTIMORE CITY
If Undar 1 Yeer | If Undar 24 Hrs. | 8, Date of UNIVERSITY HOSPITAL CENTER 8. Date of Birth (Month, Day, Year)
JAN 10 1922 NORTH CAROLINA 5. Social Security Numbar 6. Sax 7. Aga (In yrs. last birthday) 1 M XXF Months Days Hours Min 76 Yrs. 242-38-8843 Usuat Rasidence of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Xas 2 □ No MARYLAND BALTIMORE CITY N/A 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 1826 MADISON AVENUE 21217 U.S.A. 14. Race - Amaricen Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 1 Yas 2 X Yo If Yes, Giva Year or Datas: 1 Navar Marriad 2 Married 1 ☐ Yas 2 💢 💥 o Specify Specify: BLACK 3 XVidowed 4 ☐ Divorced 15. Dacedant's Education (Specify only highest grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) HAIRDRESSER 12th grade STYLIST 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumema) JOSEPH RUSSELL NELLIE J. RUSSELL 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informent's Name/Retationship (Type, Print) Baltimore, Maryland 21217
Data 20c. Location - City or Town, Stata Vinnie Henderson/Sister 1826 Madison Avenue 20b. Ptaca of Disposition (Nama of cemetary, crematory or other placa) 20a. Method of Disposition 1 ☐ Burial 2 ☐ ramation 3 ☐ Ramoval from Stata METRO CREMATORY 9-3-98 BALTIMORE, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility AM C BROWN COMMUNITY F/H P.A. 21. Signetura of Funeral Service License 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or haert failure. List only one cause on each line. Approximata Intervel Between Onsat end Daeth tmmediate Causa (Final disaasa or condition rasulting in daath) MY OCARDIAL TOPARCJ OFONARY ARTERY DISEASE
Due to (or as a conseduence of): Sequantially list conditions, if any, leading to immadiata ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PARKINSONS 24b. Were autopsy findings available prior to completion of ceuse of death? Hypertins 102 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medicel axaminar?

1 Yas 2 □ No 26. Placa of Death (Chack only one) Hospitat: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Panding invastigation 1 Yas 2 No 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida \*Certifying Physician: To tha best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and mennar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end mannar stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760 or Attending Physician: hin 24 hours aftar the Funeral Dire npletely filled in b To the Hospital o within 24 hours af To the Funeral DI completely filled in

is certificata has I

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Director: A

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "naturel", or flerns 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haaith and Manial Hygiana. Important: If Item 27 is marked other than "naturel", or items 23a any injury or other traumatic event, the Modical Examine must once.

**Physician** 

лиевіса Examiner

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State Registrar

MICHAEL 31. Data filad (Month, Day, Yaar) SEP 0 3 1998

29b. Signatura and titla of certifier

(Check only one)

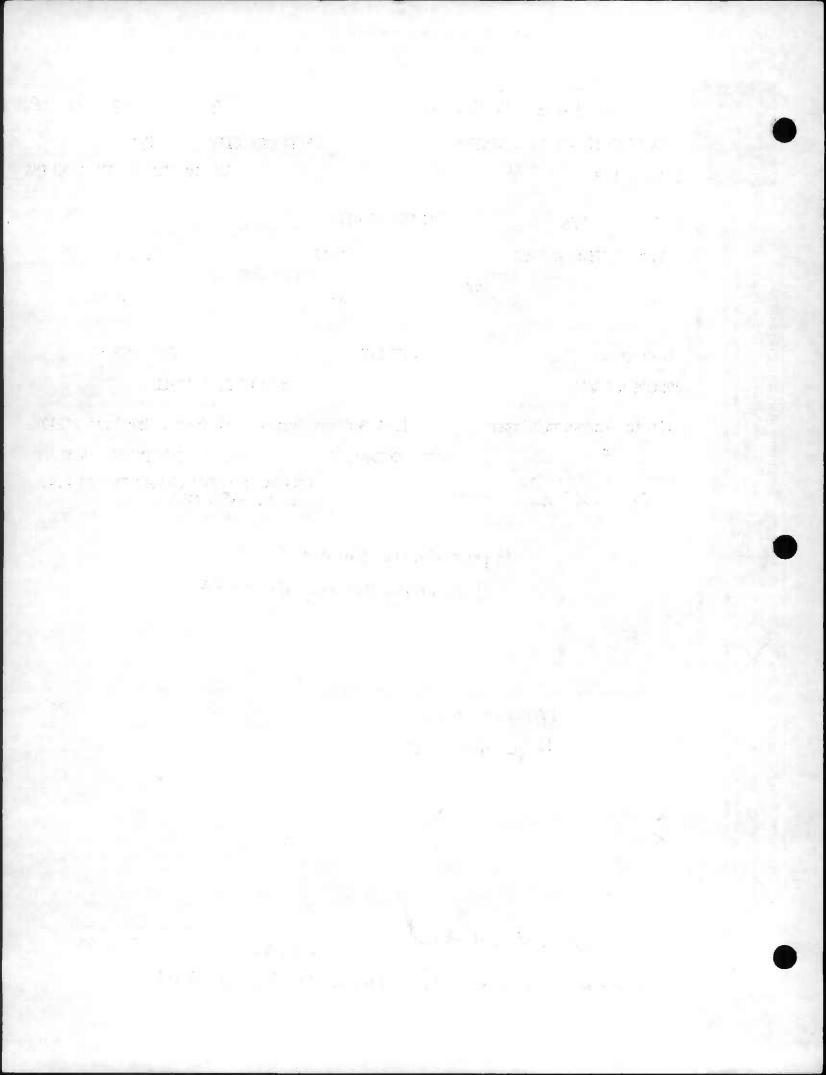
30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) KOLNICK 32 Ragistrar's Signatura

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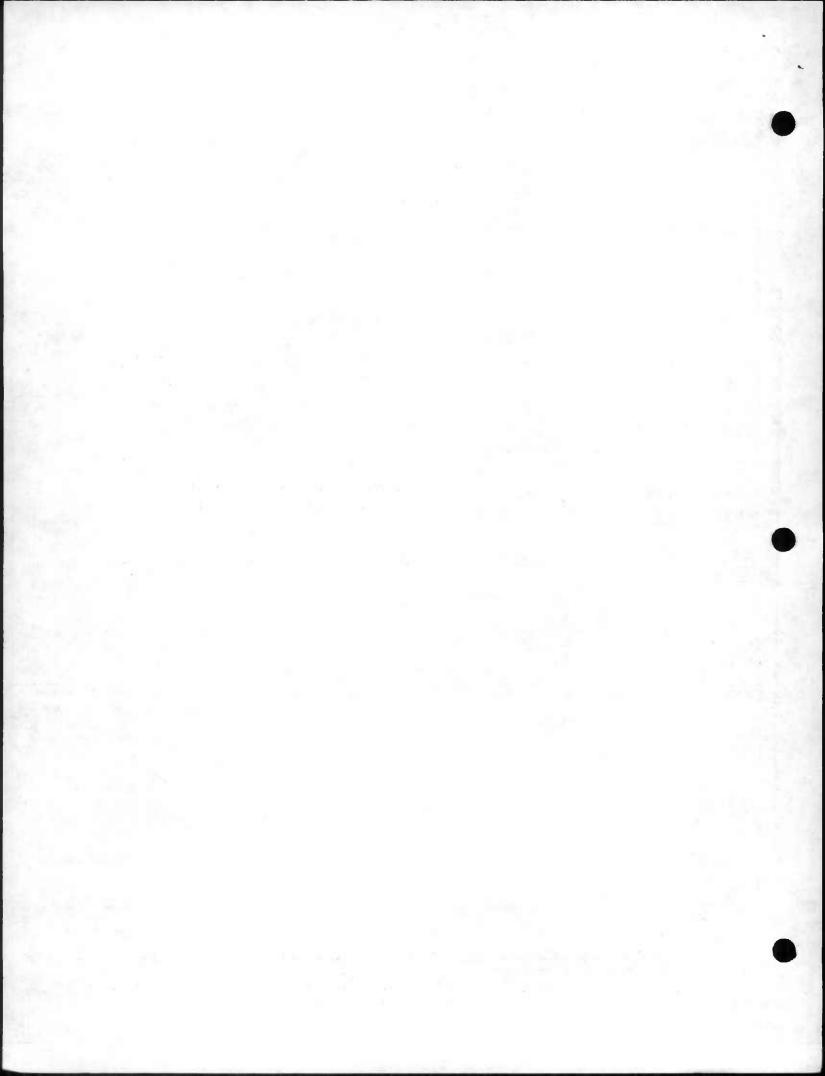
29d. Data signed (Month, Day, Year)

UNIV. OF MARYLAND



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 5 3

Physician /Medical Examiner  1. Decedant's Name (First, Middle, Last)  Nancy Marsh Riedel  2. Data of Death Month Sept 1, 1998 9:30 PM  4a Facility Nama (If not Institution, give street and number)  4619 Lathe Road  5. Social Security Number 6. Sax 1 Months Days Hours Min.  5. Social Security Number 215-09-5557  1 M 2 M F 77 Yrs.  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  1. Decedant's Name (First, Middle, Last)  2. Data of Death Month Sept 1, 1998 9:30 PM  4b. City, Town, or Location of Death Owings Mills  8 Data of Birth (Month, Day, Year)  Country)  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits					Certificate	e of L	Death		Reg. No.				
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## 46.19 Lathe Road    Construction						4	b. City, Town, or L		-		7.30 111		
Social Security Number    Displace   Company	Examiner										20320		
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Special Companies   The Control of Discontine Companies   The Contro	dead dead	11. Meritel Stetus		n U,S.	13. Was Decede	ent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Ra				
Elementary Secondary (9.13) College (14-der 5-)  Florist  Nyland Farms  18. Mother's Nema (First, Middle, Master)  Harry Edward  Lathe  Lathe  Mary Elizabeth Finney  19. Mother's Nema (First, Middle, Master)  Harry Edward  Lathe  Lathe  Mary Elizabeth Finney  19. Mother's Nema (First, Middle, Master)  19. Mother's Nema (Firs	D 12 0	3 1 Widowed 4 □ Divorced	1 ☐ Yas 2 ☒ No If Yas, Give					Rican, atc.)					
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17. Faller's Name (First, Model, Last)   Harry Edward Lathe   Harry Edward Lathe   Harry Edward Lathe   Harry Edward Lathe   Harry Edward Lathe   Harry Edward Lathe   Harry Edward   Ha	Pie de la	(Specify only highast g		_	(Give kind of work lifa. DO NOT use	k dona d e retired	luring most of worl )	king			1 40 100		
17. Father's Name (Price), Mode, Lab)   Harry Edward Lathe   Harry Edw	the the	Elementary/Secondary (0-12)	College (1-4or 5+)		Flor	ist			Mv1ar	nd Fa	irms		
Harry Edward Lathe  Mary Elizabeth Finney  15a. Monard's Name-Privation highly per Print)  15b. Meling Address (Since and Namebor or Ruse) Prince and Namebor or Ruse)  15b. Meling Address (Since and Namebor or Ruse) Print Since Address (Since and Namebor or Ruse)  15b. Meling Address (Since and Namebor or Ruse) Print Since Address (Since and Namebor or Ruse)  15b. Meling Address (Since and Namebor or Ruse) Print Since Address (Since and Namebor or Ruse)  15b. Meling Address		17. Father's Nema (First, Middle, Las	at)		1101	100	18 Mother's Nam	a (First Middle	-		I I III O		
18b. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State, Ze Code)  Mrs. Robin Caffney  19c. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State, Ze Code)  19c. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State)  19c. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State)  19c. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State)  19c. Mering Address (Sineet and Number or Paral Rotat Number, City or Town, State)  20c. Paral of Disposition (Figure 1)  20c. Paral of Disposit	8 3 5 B			.1.									
Mrs. Robin Gaffney  1197 Glenside Court Hampstead, MD 21074  200 Mainted of Disposition   Data   Dat	T Me T							J			J		
Separation   Sep	da a a a			19b.	Meiling Addrass	(Street a				n, State, Zip	Code)		
Securities   Sec	and tra	Mrs. Robin Gaffn	ey	11	97 Glens	ide	Court H	lampstea	d, MD	21074	Į.		
23a Part Enter this deases, or complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, infravious determinant. The complete cause (final disease or conditions assisted in death). Do not enter the mode of dying, such as cardiac or respiratory errest, infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. On the death Do not enter the mode of dying, such as cardiac or respiratory errest. Onset and Death Infravious determinant. Onset and Death Infravious determinant. Onset and Death Infravious determinant. On the death Do not enter the mode of dying, such as cardiac or respiratory errest. Onset and Death Infravious determinant. Onset and Death Infravious determinant. On the death Infravious determinant. On the death Infravious determinant. On the death Do not enter the mode of dying, such as cardiac or respiratory errest. On the death Infravious determinant. On the death Infravious determinant or infravious determinant. On the death Do not enter the mode of dying, such as cardiac or respiratory errest. On the death Infravious determinant. On the death Infravious determinant. On the death Do not enter the mode of dying, such as cardiac or respiratory errest. On the death Do not enter the mode of dying, such as cardiac or respiratory errors. On the death Do not enter the mode of dying, such as cardiac or respiratory errors. On t	of Feb			b. Place of	Disposition (Nam	na of	a)	Data	20c. Location	on - City or Town, Stata			
Physician Middligal Examiner To Be an expectation of the control o	9 # # 9							011	0.1		N 1 1		
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23. Part I. Enter this disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intraval Between Christ and Death (Indicical Examiner Indicided Cause (Final disease or condition resulting) in death.)  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, any, leading to immediate Cause (Final disease or condition resulting in death) List in resulting in death). List in the cause of the cau	Page Page	Stephen	m Jen	Kins	Loring	Byen	s Funera				21133		
Due to (or as a consequence of):    Due to (or as a consequence of):	Examiner 5	disease or condition a. Chronic OBStructive Lung Aiscore											
Date of the course of death but not resulting in the underlying cause given in Part L.    1   Yes   2   No   3   4   4   4   4   4   4   4   4   4	de be mouth	Cause (Disasse or Injury thet initiated avants Due to (or as a consequence of):											
24a. Was an autopsy performed?  24b. Ware eutopsy findings available prior to completion of cause of death?  1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   No   1   Yas   2   Yas	No.	resulting in death) Last											
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25. Wes cesa ratarrad to medical axaminar?  10 yas 20 No  25. Wes cesa ratarrad to medical axaminar?  11 yas 20 No  26. Place of Death (Check only ona)  27. Menner of Death  12 yas 20 No  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  28. Data of Injury  29. Cartifier  29. Certifier  29. Certifier  29. Certifier  29. Signetura end titla of certifier  29. Signetura end titla of certifier  29. Signetura end titla of certifier  29. Signetura end titla of certifier  29. Date signed (Month, Day, Year)  30. Neme and addrass of person who complated causa of death (Item 23a) (Type, Print)  ALLAN J. Chircus AD 5310 OLD COURT Rd RAN DALUSTOWN  31. Data filed (Month, Day, Year)  32. Registrar's Signature	d by							24a Was	en eutonsv	24b. W	are eutopsy findings		
1	pen seen shou	05140 00005	2-0							av	vailable prior to		
25. Wes cesa refarred to medical axaminar?    1	iaw npl									of	death?		
25. Wes cesa refarred to medical axaminar?  1	The pag							101	ras 20 No	11	☐Yas 2☐No		
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27. Menner of Death   Month, Day Year    28a. Data of Injury   28b. Tima of Injury   28c. Injury at Work?   1	direction of		Hospital:	FR/Out	tnatient 3 DO	A Othe	9f: 4 Nursing H	ome 5 Basic	lence 6 🗆 O	thar (Snecis	ful		
30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print)  ALLAN J. Chircus MD 53iD OLD COURT Rd RANDALISTOWN MD  State  31. Data filed (Month, Day, Year)  32. Registrar's Signature	nding Phy ith. : After this e funeral	1⊿Natural 5 Panding	28a. Data of Injury (Month, Day Year	28b. T	ima of 28	Bc. Injury Work	at				,,		
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30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print)  ALLAN J. Chircus MD 53iD OLD COURT Rd RANDALISTOWN MD  State  31. Data filed (Month, Day, Year)  32. Registrar's Signature	Hospitu     24 hours     Funeral Hetely fille	(Check only 2 Medical Exa	miner: On the basis of axam	knowledge, Ination end	, deeth occurred e Vor invastigation,	ot the tim	e, date end place, inion, death occur	end due to the cred et the time,	ceuse(s) end n date end plece	nennar es s , end due t	itated. o the cause(s)		
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30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print)  ALLAN J. Chircus ND 5310 OLD COURT Rd RANDALLSTOWN MD  State  31. Data filed (Month, Day, Year)  32. Registrar's Signature		cerno	lea-	mi		0	L9 085		Seal	m A -	3 1990		
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		31. Data filed (Month, Day, Year)	32. Registrar's Sig	gnature	B. 10	n v	1	1-11-0	2/1.CU.S	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	21133		

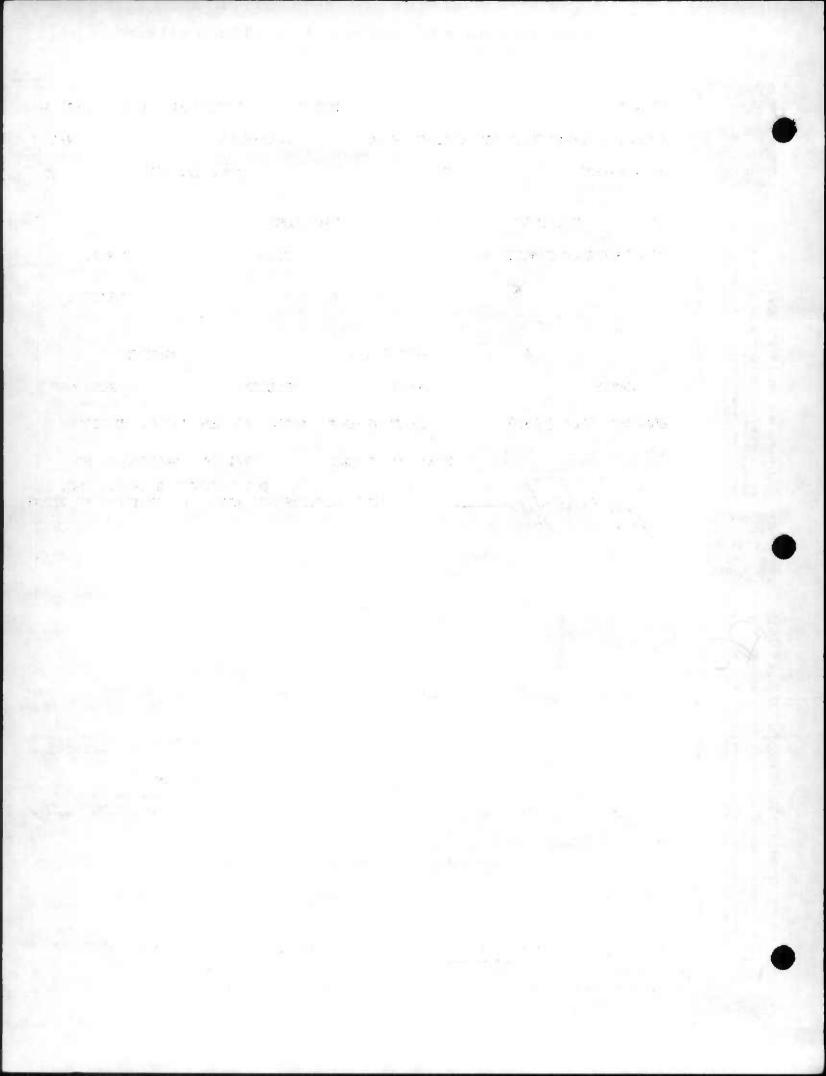


### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 695 4

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middla, Last) Day **Physician** DONALD. AUGUST 31, 1998 ROSEN 3:41 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE AT MERCY HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign
Country) 6. Sex **Funeral** Yrs. 219-05-7737 JULY 27, 80 Director MD Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or frams 23a or 28a-f show traumatic event, me Medical Examinat must be notified as 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code with 23 STONEHENGE CIRCLE #2 21208 U.S.A. Funeral 72 hours eftar deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) filed within Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) PHARMACIST PHARMACY 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middla, Last) permit. Pagas 1 end 2 should be fi Department of Health end Mantal H Important: If Itam 27 is marked of any Injury or other traumatic even HARRY ROSEN REBECCA **ACKERMAN** 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Steta, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 23 STONEHENGE CIRCLE BLANCHE ROSEN (WIFE) #2 BALTIMORE, MD 21208 Baltimore, 20b. Place of Disposition (Nama of cematary, crametory or othar placa) Dete 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) WORKMANS CIRCLE 9/1/98 BALTIMORE, MD 22. Name end Address of Facility any is SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximete Interval Between Onset and Death valions that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. **Physician** /Medical Immediate Cause (Final a 8 grs. PROST ATE CANCER disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): and Box 68760 edical Due to (or as a consequence of): Physician/M The law requires that the death 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the 1 Yes 2 No 3 Probably 4 Unknown À þ 24b. Were autopsy findings avellable prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed peed has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: funeral diractor. Be 25. Was case referred to medical examiner? 26. Place of Death (Chack only one) STELLA MAKIS Other: 4 Nursing Home 5 Residence 6 AOther (Specify) MERCY Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Panding death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Straet and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) efter 4 Homicide 24 hours e Hospital Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. 29a. Certifier edical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 10 Tomomy 0404800 selain 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 7672 FORRO, MD Berto FERNANDO 31. Date file Whorth, Ray, Year 98 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Death **GEORGE** AUGUST 25, 1998 RANDALL 13:05 pm 4e Facility Name (If not institution, give street and number) 4b, Gity, Town, or Location of Death 4c. County of Death Rince Frederick Memorial Alvert HOSPITA If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 7. Age (In yrs. last birthday) If I Inder 1 Birthplace (State or Foreign / Country) Months Days Hours 214.34.6709 1XM 20F buember 11 1936 HARYland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No TARYLAND CALVERT Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA none 20732 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 201 No If Yas, Give fro American 1□ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HANNY HAN FARMER 10 none 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) CANDALL Jah 61/ES dnA 196, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship. (Type. Print) MARLES TRINCE trederick, MARY 20b. Place of Disposition (Name of Date 20e. Mathod of Disposition 20c. Location - City or Town, Stata ery, crematory or other place) Burial 2 Cremetion 3 Removel from Stete
4 Donetjon 5 Other (Specify) Cemeter 21. Signature of Funarel Service Licens 22. Name and Address of Facility Wallace Funeral 3405 W. FRANKLIN St. BAHO, Md laclace Solar than asse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or near future. List only one cause on each line. Approximete Interval Between Onset and Death Primary Immediate Causa (Final ADENOCARCINOMA UNKNOWN disaase or condition resulting in death) 6 MONTAS Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No CHRONIC RENAL FAILURB POUNCYSTIC RENAL DISEAST 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? SECDNOPRY TO

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

Hygiene.

permit. Peges 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other treasment.

altimore, Maryland 21215-0020

88760

Box

P.O.

Records,

Division of Vital

Director

Funeral

þ

Completed

Be

Physician/Medical Completed

Be To Bis Albar

Certification:

25. Was case referred to medical examiner?

27. Manner of Death

To the Hospital o within 24 hours at To the Funeral D completely littled is

Attanding after deat Director:

3 Suicide 4 Homicide 29a. Certifier (Check only one)

Natural Accident

1 Yes 2500

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner me accurred at the time, date and place, and due to the cause(s) and manner steted. 29b. Signeture end the of certifier

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

210 No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

30. Name and address of perhaps who completed cause of death (Item 23a) (Type, Print) Dr. Charles Judge, M.D., Prince Frederick, Maryland 20678

Hospitel: 1 papatient 2 ER/Outpatient 3 DOA

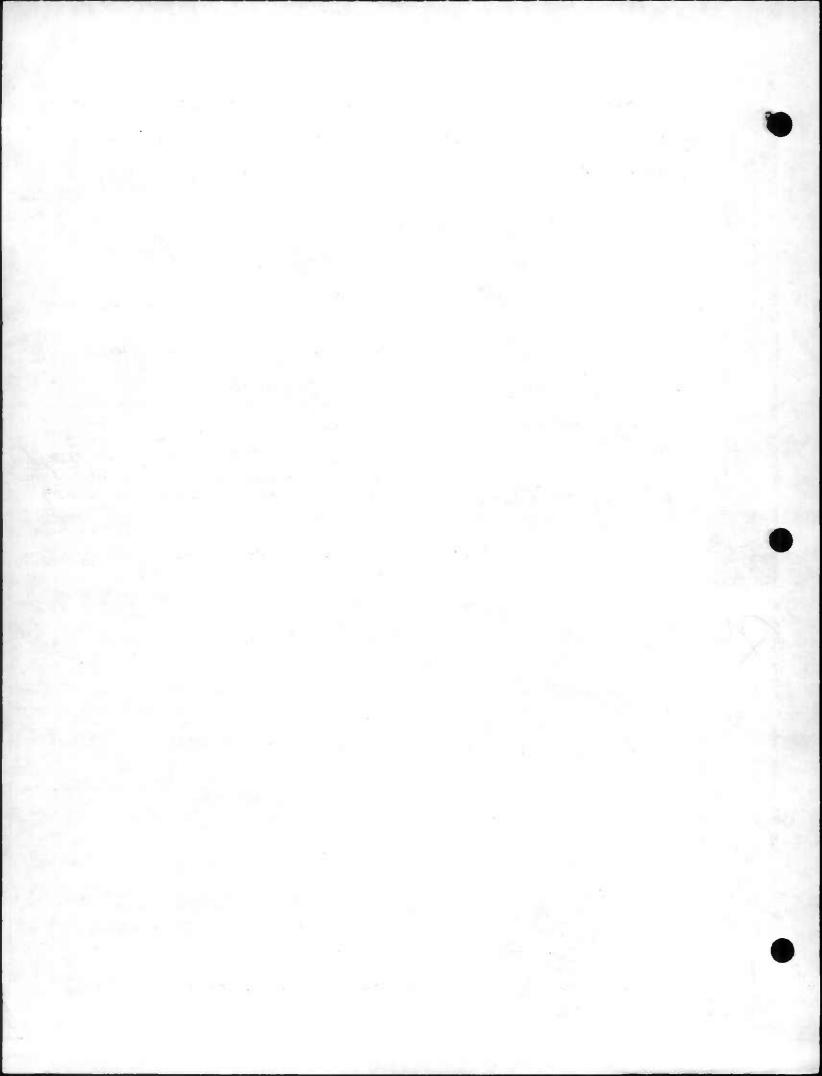
28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Registrar

Medical

2. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year C. SOUTHARD FIDELIS AUGUST 28. 1998 02:55PM /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Undar 24 Hrs. If Under 1 Yaar 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days Months Hours 1 M 2 F Director 220-07-430 SEPT. 30,1920 MD Usual Residence of Decedant 10a. Stata 10b. County 10c. City. Town or Location r than "natural", or flama 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yas 2 No Director MD. BALTIMORE TIMONIUM 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ELPHIN 201 21093 # U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Never Merriad 2 Married □Yas 2 No Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Datas: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry I Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If hem 27 is marked other trainment HOMEMAKER AT HOME 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be HONIG 0 EASTEP ALBERT FIDELIS 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 5 FUPHINCT #201 ,MD. 21093 ARTHUR L. SOUTHARD, JR, SPOOSE BALTIMORE altimore, 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY M.G. 18-31-98 TIMONIUM, MD 21. Signature of Funeral Service Licanses 22. Nama and Addrass of Facility EVANS CHAPPEL OF CHIMES 23a. Parti. Entar the disaesa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. BALTIMORE, MO. Approximata Intarval Between Onset end Death **Physician** /Medical Immediata Causa (Final CARDIORESPIRATORY ARREST disaasa or condition resulting in death) Examiner Dua to (or as a consequance of): SEPTIC SHOCK Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated avants resulting in death) Last Dua to (or as a consequence of): GASTROINTESTINAL GANGRENE edical Due to (or es e consequence of) Box ( d PNEUMONITIS Physician/M Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23h. Did tohacco use contribute to the cause of death? o signed by i 1 Yes 2 No 3 Probably 4 Unknown P Records, 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen: 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☑ No certificate of Vital or Attending Physician: director Be 25. Was case refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 5 Panding within 24 hours after death.

To the Funerel Director: Af Invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicida Hospital 29a. Cartifiar 🗹 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and dua to tha cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of cartifiar 29c. License number 29d. Data signed (Month, Day, Year) 9 686 .28.9 10m 10 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

State Registrar 31. Data filed (Month, Day, Year) SEP 0 3 1998

-

/ /AAA

32 Registrer's Signatura

YASEEN A. TOMHE, M.D., 120 SR. PIERRE DRIVE, S-204, TOWSON, MD.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 1998 Sept 3:15 PM Garrett Smith 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Randallstown Baltimore If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10M 20F 213-52-6764 50 April 17, 1948 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 Cliffedge Road 21208 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ₺ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)

Disabled

20b. Place of Disposition (Name of cemetery, crematory or other place)

8134 Township Drive

Sr.

Smith.

Unemployed

20c. Location - City or Town, Stete

Laurel, Maryland

Harmon

21117

18. Mother's Name (First, Middle, Maiden Sumame)

Date

9/3

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Florence Louise

Owings Mills, Maryland

r than "natural", or hame 23a or 25a-f shor the Medical Examiner must be notified at 72 hours after Hygiene. permit. Pages 1 and 2 should be fits.
Department of Heath and Mental Hy important; if hear 27 is marked other any injury or other transmissed other.

altimore, Maryland 21215-0020

Physician

/Medical

Examiner

10a. State

8th

17. Father's Name (First, Middle, Last)

Mr. Patrick Smith

4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type, Print)

Leo

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

James

20a. Method of Disposition

Directo

Funeral

à

Completed

8

**Funeral** 

Director

show

Physician /Medical Examiner

P Physician/M P

Box 68760

P.0.

Division of Vitai Records,

peed a certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

Balto. Washington Crem 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Loring Byers Funeral Directors, Inc. ensins 8728 Liberty Road Randallstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to control examiner? 8 26 Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 5 Residence 6 Other (Specify) 1 Yes 20 Certification: To 27. Manner of 86 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury a Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending 1 Yes 2 No investigation 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier \*\* Committing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The properties of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certif 29d. Date signed (Month, Day, Year)

State Registrar

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year)

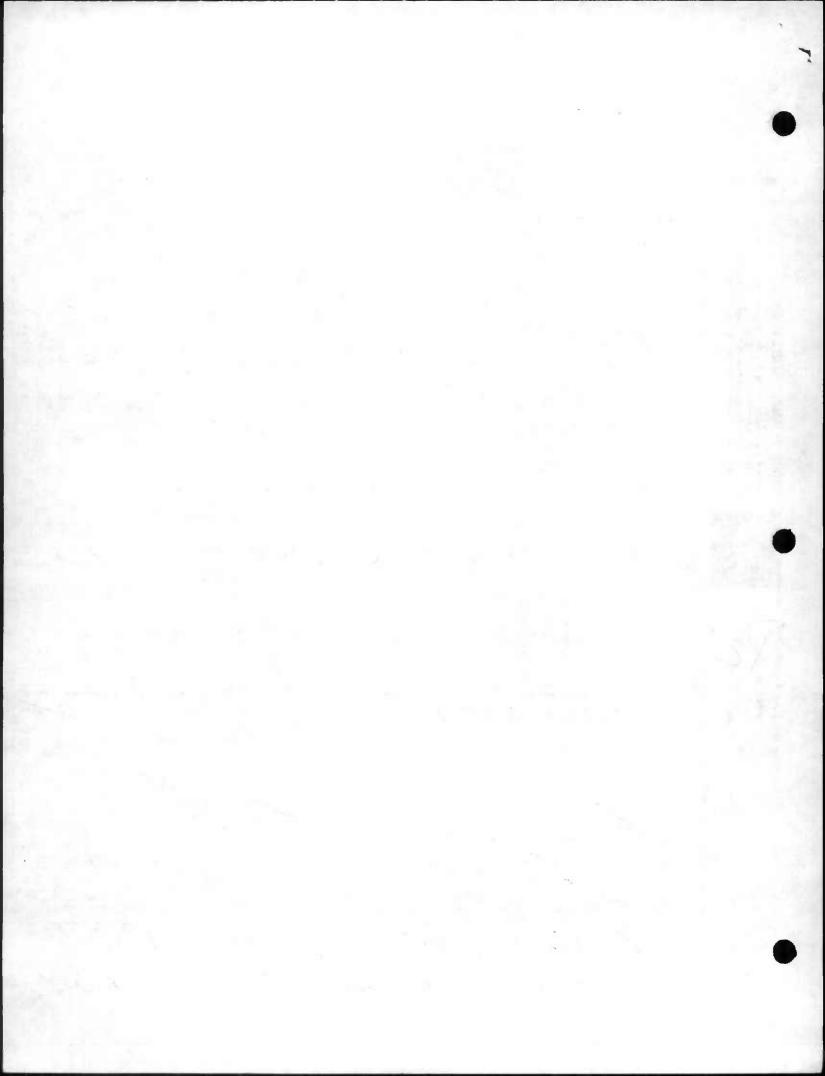
03

**ORIGINAL** 

accentree

who completed cause of death (Item 23a) (Type, Print)

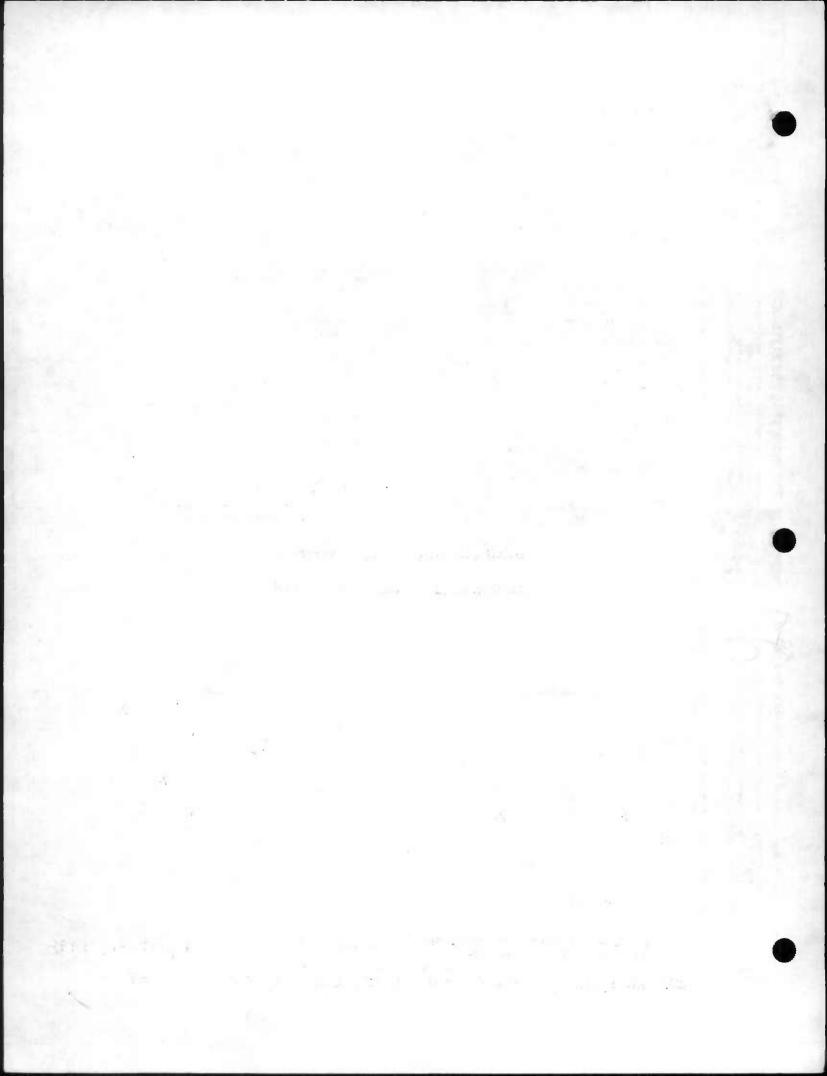
32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 8 2 6 9 5 8

				Ce	rtificat	te of	Death			Reg. No.				
Dhuninin	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Year	3. Time of Death		
ysician Medical	MARIAN			Sı	HAW				AUGUST		1998	14:16		
miner	4a Facility Name (If not institution	, give street and r	number)				4b. City, To	wn, or Lo	ocation of Death		4c. County of Death			
	THE JOHNS HO	PKINS HO	SPITAL				BALTI			N/A				
eral	5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th ly, Year)	9. Birtho	place (State or Foreign	1	
tor	213-32-4284	10 m 2%	63	Yrs.					OCT. 1	2,1934		MD		
	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation			-11-2			1	Od. Inside City Limits		
ŏ	MD N/A			LTIMOR								1X Yes 2 No		
Director	10e. Street and Number		טר	IL I I I I I I I	10f. Zic	o Codo					_			
ā		DAND								10g. Citizen of		niy r		
Pral	2108 CLIFFWOOD		ecedent Ever in U	10 12		1206	Jienania Ori	oin? (So	acity Vac or No	U.S.A	ce - Americ	en Indian		
Funeral	1 Never Merried 2 Marr	Armed	Forces?	10.	If Yes, spe	cify Cub	an, Mexicar	, Puerto	ecify Yes or No Rican, etc.)	Bte	ck, White,			
by	3 Widowed 4 Divorced	If Yes, C	Give'		1 Yes	2 🗆 📉 No	Specify:			Speci	Y: AFR	AMERICAN		
	15. Decedent			16a. Dece	dent's Usu	el Occur	pation	-		16b. Kind of E				
Completed	(Specify only highes	t grade complete		(Give	kind of wo	ork done	during mos	t of work	ing					
E	Elementary/Secondary (0-12)	College	(1-4or 5+)	NUR	SE'S	AID				NURSIN	G HOM	E		
Be C	17. Father's Name (First, Middle,	Last)				25.7	18. Mofhe	er's Name	e (First, Middle,	Maiden Suma	me)			
To E	WESLEY KELLY						IDA	٧. ١	KELLY					
	19a. Informant's Name/Reletions	hip (Type, Print)		19b. Meili	ng Address	s (Street	end Numbe	er or Run	al Route Numb	er, City or Town	, State, Zip	Code)	-	
	IDA V. KELLY (	MOTHER)		2002	N. WC	DLF :	ST. BA	ALTO.	. MD 21	213				
	20s. Method of Disposition		and the second second	Place of Dispo	sition (Nei	me of other ple	ce)		Dete	20c. Location	- City or To	own, State		
	1 ☐ Buriat 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (S)		m State	TO. CE			-	SEPT	.8,1998	BALTO.	MD			
d	21. Signature of Funeral Service I	igenson ENG					ss of Fecili	У	RAL HOM					
To Be Comp	M. M.	11/11	la 1	13	IEP E	3KU II	HEKS I	FUNE	KAL HUM LTO. MD	E P.A.				
	23a. Pari 1. Empir the distance, or shock or heart failure. List	complications the	t coused the deel								1	Approximate		
in	shock, or hourt failure. List	only one dause or	waidh linja.								1	Interval Between Onset end Death		
al	Immediate Cause (Final disease or condition	ES	CHERICI	4 A L	COLI	SE	PSIS				t	2 days		
	resulting in death)													
ė		ESC	HERICHI				MONI	A			1	3 2645		
Examiner	Sequentially list conditions	b		or es e consec							1	3 00 75	-	
EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events													
io i	Cause (Disease or injury that initiated events resulting in death) Last	С	Due to (d	or es e conseq	uence of):						t			
Peg	resulting in obdut/ Last	to a first									i			
2		d											_	
Physician	Part II. Other significant conditio	ns contributing to	death but not res	ulting in the u	nderlying o	ceuse giv	ven in Pert I		23b. Did	tobacco use c	ontribute to	o the cause of death	?	
4									10	Yes 2 No	3 D Pro	bably 4 Unknow	m	
by								-						
	1500									an eutopsy	av	ere eutopsy findings ailable prior to		
Completed											CO	mptetion of cause death?		
E									10	Yes 210 No	10	Yes 2 No		
Bec	25. Was case referred to medical						26 Place	of Deet	h (Check only o	•			-	
To B	examiner? 1 ☐ Yes 2 🕱 No	Hospital:	XInpatient 2	ER/Outpatier	nt 3 D	OA Oth	nor:		me 5 Resi		her /Snecii	(v)		
	27. Manner of Death	28a. Det	e of Injury	28b. Time o		28c. Inju		-	28d. Describe			777	-	
of the	1 Natural 5 Pending 2 Accident investig		onth, Day Year)	Injury	м		rk?  Yes 2 🗌	No						
5	3 ☐ Suicide 6 ☐ Could r	ned 286. Pla	ce of Injury - At h	ome, farm, str	reet, fector	y, office			28f. Location (	Street and Num	ber or Run	si Route Number,	-	
Certification:	4 Homicide	buil	lding, etc. (Speci	(y)					City or To	wn, State)				
	29a. Certifier 1∑ Certifyin	Physician: To the	he best of my kno	wledge, deatl	h occurred	et the tir	me, date en	d place,	end due to the	cause(s) and n	ienner es s	stated.		
P	29a. Certifier (Check only one)  29a. Certifier (Check only one)  Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and men occurred at the time, date end place, and men one)  Check only one)  Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and men occurred at the time, date end place, and manner stated.											o the cause(s)		
2	29b. Signature and title of certifier		ACATEC .	. >	29	c. Licens	se number			29d. Date sign	ed (Month,	Day, Year)	Т	
	165	illiam L	CICER	עוָט.	F	265	-00	00		August	31.	1998		
	30. Name and address of person			n 23e) (Type	Print)								-	
	IAN KROP M.D		North Wo			Ba	Itimo	re. 1	Marylan	2128	57			
tate	31. Date filed (Month, Day, Year)		Registrar's Signa		•			•					_	
State istrar	SER 0 3 19	98 3	-www	4	10-									



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 26959 Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Juseph 1858 Spurrier 98 31 /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Trauma Bultimore Center n/a if Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Months 69 Yrs. Director 214-26-2091 Sept.10,1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f short the Madical Examiner must be notified at 1 Yas 2 No Maryland Anne Arundel Linthicum Heights Direct 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? United States
o- 14. Race - Amarican Indian,
Black, White, etc. 524 Edric Drive Funeral 21090 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 ☑ Yes 2 □ No
If Yes, Give 1948-52
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 police officer law enforcement i. Peges 1 and 2 should be filed w tment of Heelth and Mantel Hygia tant: If item 27 is marked other ti jury or other traumatic event, m 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) Be Robert George Spurrier Alice Elizabeth Charlet 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Dolores Spurrier - wife 524 Edric Drive, Linthicum Heights, MD 21090 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burlal 2 ☐ Cremation 3 ☐ Ramoval from Stata permit. Pege Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 9/4/98 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue Baltimore, MD 21229 23a, Part Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock or haart failura. Listonly one causa on each line. Approximate Interval Between Onset and Daath **Physician** /Medical Immadiata Causa (Final Multiple organ dailure day diseasa or condition rasulting in daath) **Examiner** Dua to (or as a consequanca of): Examiner 5 days SEPSIS Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated evants resulting in death) Last attending physician end for use as the burief-tren Due to (or as a consequence of): lef + in fect Physician/Medical Dua to (or as a consequence of): Part Ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco uss contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Birentrice les heart failure congestive text py 24b. Ware autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy Completed chronic renal failure 1 Yes 2 No 1 ☐ Yas 2 ☐ No Peripheral vasculardisease director 25. Was casa rafarrad to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1⊠Jnpatient 2□ ER/Outpatient 3□ DOA Othar: 4 Nursing Home 5 Residanca 6 Othar (Specify) 1⊈Yes 2□ No 2 funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation NUNE 2 Accident NONE 3 Suicida 6 Could not be datermined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rurel Route Number, City or Town, State) in by 4 | Homicide

Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RAdons Couley

en trollave atendo

MD

32. Registrar's Signature

30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print)

SEP 0 3 1998

11000

29c. Licansa number

29d. Data signad (Month, Dey, Year)

Shocktowne Certer Rothward

the the death certificate be executed Records, P.O. Box 68760 Division of Vital or Attending efter deeth. Director: Aft To the Hospital or within 24 hours eff To the Funeral Di completely filled in

with the Meryler

Hygiene.

altimore, Maryland 21215-0020

After

Registrar

Medical

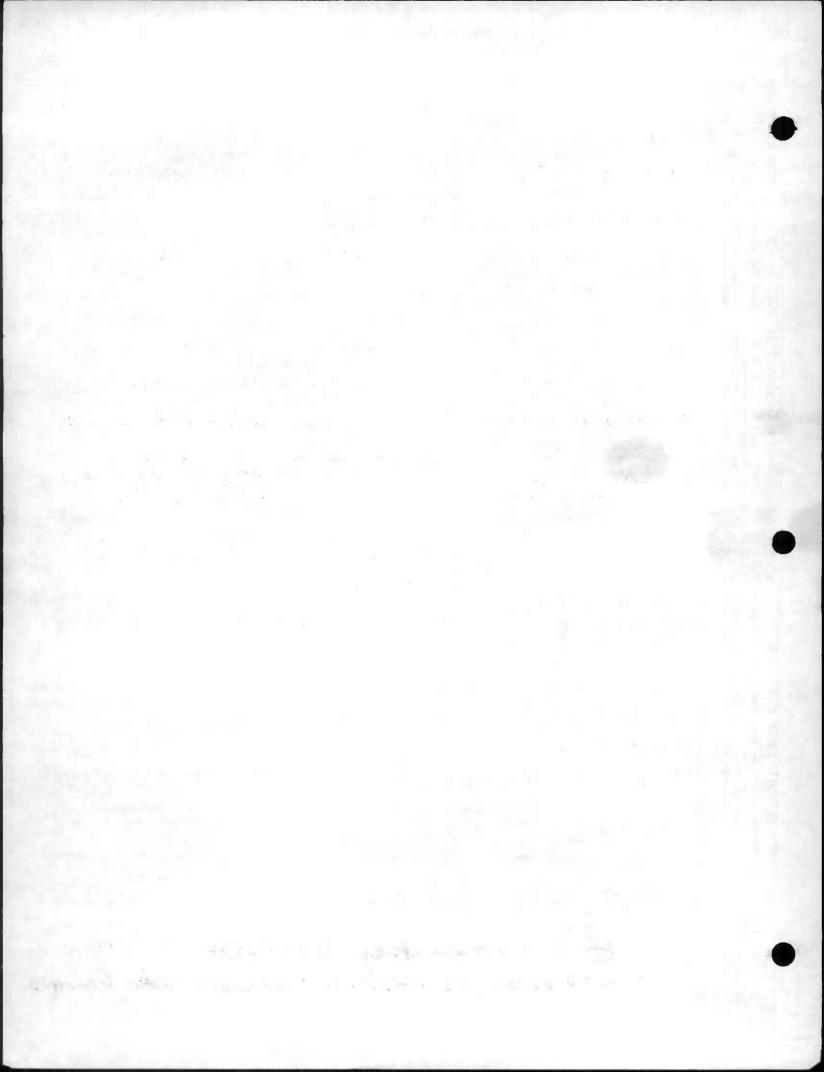
29a. Certifier

(Check only one)

29b. Signature and title of a

31. Date filed (Month, Day, Yaar)

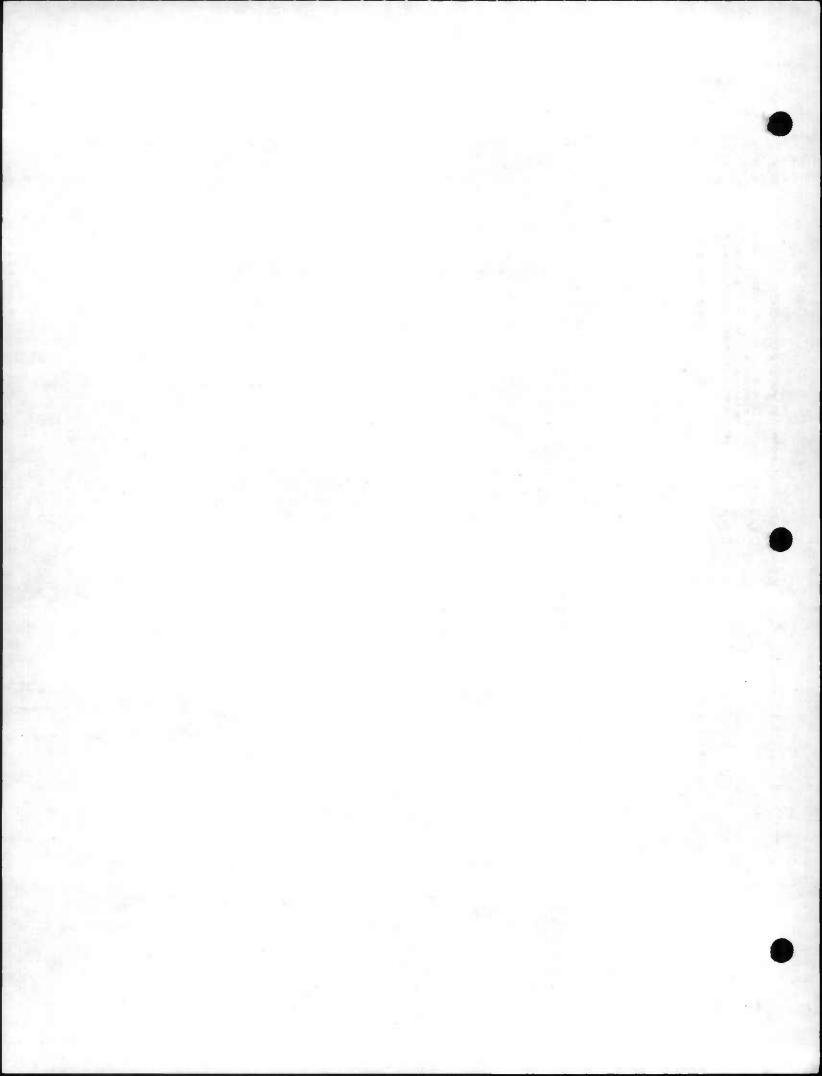
DHMH 16 Rev 6/95



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Physician	Decedent's Neme (Firs	it, Middle, La	ist)					2. Dete of D Month		Yeer	3. Time of Death		
/Medical	Sophie H.							Augus			1250 P		
Examiner	4e Facility Neme (If not in	nstitution, giv	re street end numbe	or)			4b. City, Town, or	Location of Dea	th 4c. County of	of Deeth			
	Augsburg	Luth.	. Home			Security 1	Baltimo	ore Co	Ba1t	imo	re		
uneral	5. Sociel Security Number			Age (In yrs. la	ast birthday)	If Under 1 Year Months Devs	If Under 24 Hr Hours Mir	S. 8. Dete of B	te of Birth 9. Birthplece (Stete onth, Day, Year)				
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	Usuel Residence of Dece							1-3- 2- 10/0  110					
al', or items 23a or 23a-f show Examinet must be pourted at by Funeral Director	10e. Stete 10b.	County		10c. City,	, Town or Lo	ocation			10d. Inside City				
or 28a-f s be protected	Md Ba	1time	ore	F	Balti	more Co	. Md.				1 Yes 2		
9	10e. Street and Number				- C- C- T	10f. Zip Code			10g. Citizen of W	of Whet Country?			
0	5534 Whi	tby	Road			21236			USA				
free met	11. Maritel Status		12. Wes Deceder	nt Ever in U.S	S. 13. V	Wes Decedent of I	Hispanic Origin? (	Specify Yes or N		- America	an Indien,		
F 15	1 □ Never Merried 2	☐ Merried	Armed Force	s?		If Yes, specify Cub	an, Mexican, Pue	rto Rican, etc.)		, White, e			
by	3 Widowed 4 □ D	2000	If Yes, Give Yeer or Deter			1 Yes 2 No	Specify:		Specify:	7.71			
2	100000				40- D	1-4-10-10-1			1401-140		nite		
Completed		ecedent's Ed y highest gra	ade completed)		(Give	dent's Usuel Occu kind of work done DO NOT use retire	during most of w	orking	16b. Kind of Bus	iness/ind	ustry		
To Be Comp	Elementary/Secondary	(0-12)	College (1-4o	r 5+)									
			NA		Но	memaker			Home				
Be	17. Fether's Neme (First,		)				18. Mother's No	eme (First, Middle	e, Maiden Sumame	)			
2	Charles	Hoh1	2014				Barba	ara Som	mers				
	19e. Informent's Neme/Re					ng Address (Street	and Number or F	Rural Route Num	ber, City or Town, S	Stete, Zip	Code)		
	Florence	Zimme	erman/da	ughte	r	3331 0	rlando	Ave. B	altimor	e, l	1d 2123		
	20e. Method of Disposition	n				sition (Neme of		Dete ,	20c. Location - 0	City or Tox	wn, State		
	1 Buriel 2 □ Crer			9	kwoo	netory or other ple d Ceme		9/4/90	Balt	i ma			
	4 Donetion 5 DC			141				11/10					
200	21. Signature of Funeral S	Service Licer	1800		22	Name end Addre Hartley	Mille:	Funer	al Home	. CI	HTD.		
M.	Janle	- Type	200			7527 Ha			ltimore				
	23a. Pert1. Enter the dise shock, or heart feilur	ese, or com	plications that caus	ed the deeth.	Do not ent	er the mode of dyi					Approximete		
n	SHOOK, OF HOME TOTAL	ie. List Offiy	One ceuse on eech	IIIIO.						1	Intervel Between Onset and Death		
i -	Immediete Cause (Finel				1 1	0				1	A		
aminer	diseese or condition resulting in death)		θ		ach	sdreton	~			1	5 days		
				Due to (or	es e conseq	quenca oi):				1			
nin			b					i					
XB	Sequentially list condition if any, leeding to immedia cause. Enter Underlying Ceuse (Diseese or Injury that initiated events	s, ete		Due to (or	es e conseq	juence of):				į			
10	Ceuse (Diseese or Injury		c				į						
op	resulting in death) Last						į						
Me		4											
2			<b>u</b> .							1			
Sic	Pert II. Other significant of	ther significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contributa to the cause				
Physician/M	0-3		1 Yes 2 No 3 Probably 4										
by	For	3 m, 10	Luenia, s	OID									
									s en eutopsy		re eutopsy finding		
Completed								pen	formed?	con	pilable prior to appletion of cause		
E										Of C	leeth?		
ပိ								1 🗆	Yes 2. No	1 🗆	Yes 2 No		
8	25. Wes case referred to a examiner?	medical						eath (Check only	one)				
To	1 ☐ Yes 2 ☑ No		Hospitel: 1 ☐ Inpa	tient 2 E	R/Outpatien	I 3 DOA	her: 4 Nursing	Home 5 Res	sidence 6 Othe	r (Specify	)		
Ë	27. Menner of Deeth	Dondina	28e. Dete of in (Month, E	jury Dev Year)	28b. Time of Injury	28c. Inju Wo	ry et	28d. Describe	how injury occurre	d			
atic	2 Accident	Pending investigetion		,	,,		Yes 2 □ No						
Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	286. Plece of I	njury - At hon	ne, farm, str	eet, fectory, office		28f. Location	(Street and Numbe	r or Rura	Route Number,		
er.	4   Homicide		building,	etc. (Specify)				City or 10	own, Stete)				
	29e. Certifier	ertifying Ph	ysician: To the bas	t of my know	ledge deeth	occurred at the ti	me date and place	e end due to the	cause(s) and mer	ner as st	eted		
edical		edical Exam	curred et the time	, date and plece, e	nd due to	the cause(s)							
Me	29b. Signeture and title of	contifier	end menner	310100.		29c. Licens	ea number		29d. Date signed	(Month I	Day Voort		
	S.S. S.G. IOCOLO MING CITIO OF	-							Lou. Date Signed	inionali, L	ray, roary		
	7	7				1	27573		AUG ?	51,10	388		
	30. Neme end address of	person who											
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tate	31. Dete filed (Month, Dey	Year)	32. Regis	trer's Signetu	ire								
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		1000	720 .	21 1	6								

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Dey WALTER THOMPSON 4b. City, Town, or Location of Death 28 98 17:34 4c. County of Death 4a Facility Name (If not institution, give street and number) Mercy Medical Center
5. Sociel Security Number 6. Sex. 7. A Baltimore Age (In vrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) Sex 1 M 2 □ F Months Hours Min 60 Yrs. Usual Residence of Decadent 10a State 10b. Count 10c. City, Town or Location 10d, Inside City Limits Yes 2 No MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U . S . A .

14. Race - American Indian,
Black, White, etc. 21209 4700 Greenspring Ave Apt T-4 I. Was Decedent Ever in U.S. Armed Forces?

Yes 2 No
If Yes, Give
Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: 3 □ Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade NA Housekeeper Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Thompson Sr. Gertrude Harris 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Relationship (Type, Print) Ernestine Thompson-wife 4700 Greenspring Ave, Baltimore Md 21209 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Nurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest Vet 9/3/98 Owings Mills, Md 21. Signature of Juneral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215

anter the mode of dving, such as cardiac or respiratory arrest.

Approximate he disease, or complications that caused the deeth. Do not e heart feilure. List only one cause on each line. Intervel Between Onset and Death Immediate Cause (Final (Nyocardial disease or condition resulting in death) unknown Congestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for es e consequenca ot): Due to (or as e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an eutopsy performed? 24b. Were eutopsy tindings available prior to completion of cause of death? 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

/ Is marked other than "natural", or items 23e or traumatic event, the Medical Examiner must be

Hygiene.

Pages 1 and 2 should be 1 nent of Heelth and Mental

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filed within 72 hours after death

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

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Completed

Be

Examiner physician and s the bunal-transit cate be exec edical Physici þ

page 2 s this funeral

Completed

Be

Certification: To

edical

29a. Certifier

29b, Signatur

(Check onl

Division of Vital Records, P.O. Box 68760, or Attending Physicien: death. efter death Director: 24 hours e Hospital within 2 the To

Registrar

25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 ANatural 5 Pending 6 Could not be 3 Suicide 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) investigation

28b. Time of 28c. Injury et Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

ner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and menner stated.

29d. Dete signed (Month, Day, Year)

30. Name end add ups of person who completed cause of deeth (Item 23a) (Type, Print)

McP herson

31. Date tiled (Month, Day, Year)

SEP 0 3 1998

32. Registrar's Signature

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

| Medical Example: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the

DHMH 16 Rev 6/95

Mercy Medical Center, BALTIMOR MD 21201

AND THE RESERVE OF THE PARTY OF

4 5 4 11 11 11					Cer	tificat	e of	Death			Reg. No.		
1. Decedent's Neme (I	First, Middle, La	ist)								2. Dete of De		Vere	3. Time of Deeth
Veronica M	ary Tul	lly								Month August	Dey 19	998	11:30 pm
4e. Fecility Name (If no	ot institution, giv	e street and no	umber)					4b. City, To	wn, or L	ocation of Deetl		y of Deeth	
Greater Ba	altimore	Medic	al Cent	er				Tows	on		Balt	timor	e
5. Social Security Num 214-22-923	rthdey) Yrs.	If Under Months	1 Yeer Deys		24 Hrs. Min.	8. Dete of Bir (Month, De February	y, Yeer)	Cou	plece (Stete or Foreign intry)				
Usuel Residence of De													
Maryland F	n or Loc	ation							10d. Inside City Limits 1 ☐ Yes 2 No				
10e. Street end Number 703 Canber		ele				10f. Zip	Code 204				10g. Citizen of United		
11. Maritel Status  1  Never Married  3  Widowed 4 [	2 Married	12. Wes Dec	2 No	U,S.	S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)  14. Race - Amer Bleck, White						ce - Amen	ican Indien,	
	5. Decedent's En		)	168	. Deced	ent's Usue	ol Occu	pation during mos	t of worl	king	16b. Klnd of E	Business/Ir	ndustry
Elementary/Seconds 12	ary (0-12)	College	(1-4or 5+)	A		istra					Teleph	none	Company
17. Fether's Neme (Fir	st, Middle, Last,	)						16. Mothe	er's Nam	e (First, Middle	Maiden Sume	me)	
Edward Jos	seph Tul	lly						Vero	nica	a Mary M	<b>c</b> Grath		
19e. Informent's Neme			er	-				Circl		ral Route Numb			p Code)

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once.

Physician/Medical Examine

þ

Completed

Bei

Certification: To

edicai

25. Wes case referred to medical

1 Natural

3 Suicide

29a. Certifier (Check only

**Physician** 

/Medical

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Madical Examiner man be notified at

Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or item

Tully, Veronica

death with the Maryland

Directo

by Funeral

Completed

Be

2

4 ☐ Donetion 5 ☐ Other (Specify)

21. Signeture of Funerel Service Licensee

**Physician** /Medical Examiner and

signed by the a The law requires that the certificate has been si irector, page 2 should

To the Hospital or Attending Physician: After this 24 hours within 2

Box Division of Vital Records, P.C. s after dec. filled in by

> State Registrar

22. Name and Address of Facility
Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, MD 21212 Approximete Intervel Between Oneet end Deeth 23a. Pert1. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediete Ceuse (Finel diseese or condition resulting in death) e. Respiratory Failure Days Due to (or es e consequence of): Pulmonary Edema and Congestion Days Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown

Greenmount Crematory

Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 A No 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signature end title of certifler 29c. License number um

D27740 08/31/98

26. Place of Deeth (Check only one)

24e. Wes en eutopsy performed?

1⊠ Yes 2□No

29d. Date signed (Month, Dey, Yeer)

9-1-98

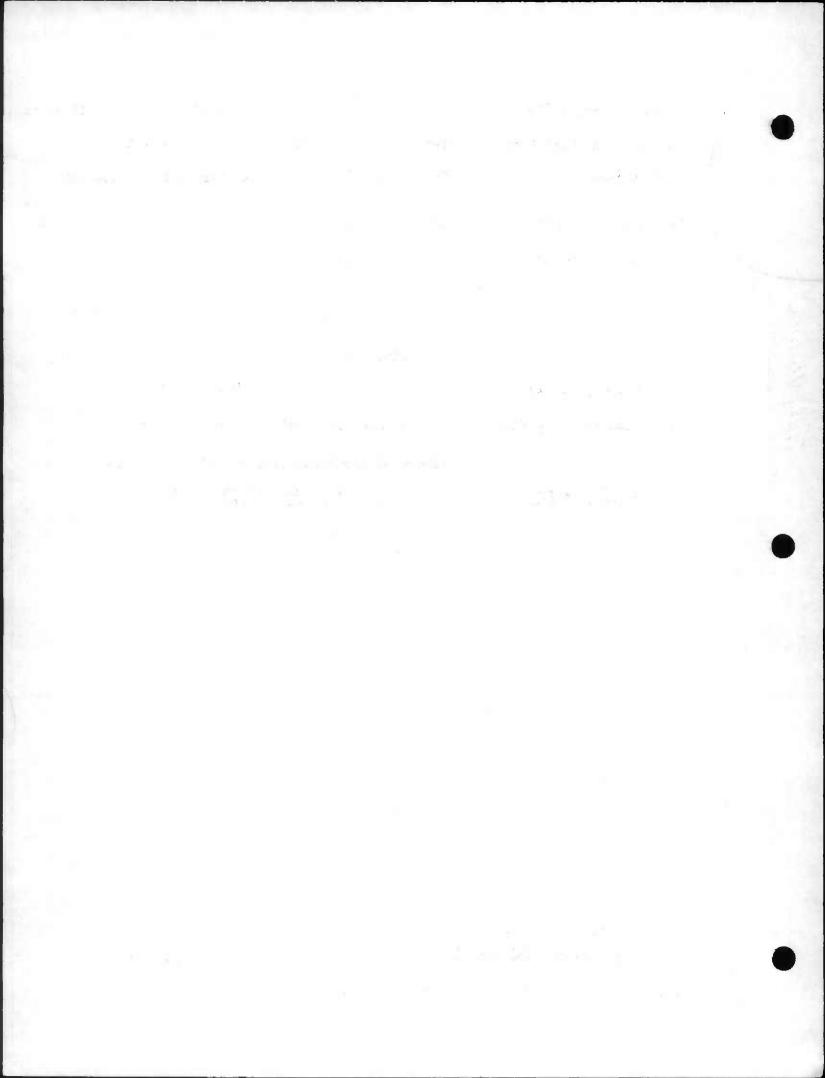
Baltimore, MD

24b. Were eutopsy findings evelleble prior to completion of cause of deeth?

1 Yes 2 No

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print)

M.D. GBMC 6701 Charles St, Towson MD 21204 Robert A. Palermo, Ŋ 31. Date filed (Month, Dey, Year) 1998 32. Registrar's Signature sporks



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State of Maryland / Department of Health and Mental Hygiene	5 4	D'	y i	0
Cortificate of Doath				

21010					Cei	titicat	e of l	Death		Re	g. No.			
an 1. C	Decedent's Name									Date of Death Month	Day	Year	3. Time of D	
al	Sandra	L.	Timchul					01. T		ugust			10:50	
er <sup>4e</sup>	Facility Neme (I	f not Institution,	give street end nu	imber)			4	lb. City, Town,	or Location	on of Deeth	4c. County	-		
	niversit Social Security N		aryland, <sup>6. Sex</sup>	Shock T		If Under		Baltimo   Munder 24	re Hrs. 8	Date of Birth		Year   1998   10:50		
	219-58-1		1□M 2□F		35 Yrs.	Months	Days		vin. Ju	Date of Birth (Month, Day, Ine 27	,1963	Day Year 31 1998 10:50 4c. County of Death N/A  1963 9. Birthplece (State or Flack/T/Y) and  10d. Inside City to the Country? U.S.A.  14. Race - American Indien, Black, White, etc.  Specify: White b. Kind of Business/Industry  Food Service iden Sumeme)  Sity or Town, State, Zip Code) Maryland 21057 b. Location - City or Town, State monium, Maryland  Funeral Home, In aryland 21204  Approximate Interval Betwee Onset and Death of Completion of Cau of deeth?  2 No 3 Probably 4 Town  See 6 Other (Specify) injury occurred  Will Coll (Flore)	land	
Usi	ual Residence of	Decedent												
10a	a. State	10b. County		10c. Ci	ity, Town or Lo	cation								
	Md.	Ca	rroll			Wes	tmin	ster				1 Yes 2		
10e	Street and Nur					10f. Zip		1157		10	_		-	
		ykesvil	le Road		10				0.40					
	Maritel Status  1 ☐ Never Marri	lad 21X Marria	Armed F		7,5.	Yes, spec	cify Cuba	ispanic Origin' in, Mexicen, P	uerto Rica	in, etc.)				
	3 Widowed		If Yes, G Year or I	ive		☐ Yes	No □	Specify:			Specify	Whi	te	
	10	15. Decedent's	Education		16a. Deced	lent's Usua	al Occup	ation			16b. Kind of B	usiness/In	dustry	
E	(Spec Elementary/Seco		grede completed) College (	1-4or 5+)	life. I	DO NOT us	se retired			orking				
			2		Owner	of B	aldw	in Foo					1ce	
17.	Father's Neme							18. Mother's Eve	Name (Fi	rst, Middle, M Shade	feideri Sumen	ne)		
	Stepha		chula		45		(0:				04	C4	Onde:	
	a. Informant's Ne c. Steph		ip <i>(Type, Print)</i> :hula/Fat	her	19b. Mailir 4400	ng Address Meado	wcli	ena Numbero Lff Roa	d Gle	oute Number, en Arm	, Mary.	Siete, Zip Land	21057	
	Method of Disp			20h	Place of Dispo	sition (Ner	ne of							
1\(\times \) Burial 2\(\times \) Cremation 3\(\times \) Removal from State 4\(\times \) Donation 5\(\times \) Other (Specify)    1\(\times \) Burial 2\(\times \) Cremation 3\(\times \) Removal from State 4\(\times \) Donation 5\(\times \) Other (Specify)    2\(\times \) Cremetery, cremetery, cremetery or other place)    2\(\times \) Cremetery, cremetery or other place)    3\(\times \) Algorithm 3\(\times \) Cremetery, cremetery or other place)    4\(\times \) Donation 5\(\times \) Other (Specify)    5\(\times \) Cremetery, cremetery or other place)														
21	Signature of Fu													
	100-	0 1	10	0/		050 Y								
23	la. Part 1. Enter th	he disease, or	omplications that nly one cause on	and the dee	th. Do not ent								Approximate	
	shock, or hea	rt failure. List o	nly one cause on	oden line.								- 1		
Imi	Immediate Cause (Final disease or condition  Multiple Induries													
disease or condition resulting in death)  Due to (or as a consequence of):										1				
Due to (or as a consequence of):    Due to (or as a consequence of):														
Se	quentially list co	nditions,	b	Due to (	or as a consec	uence of):								
cei Cei	iny, leading to imuse. Enter Unde	nmediate orlying										t l		
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underfying Cause (Disease or Injury that initiated events resulting in deeth) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):														
_														
Par	t II. Other aignif	icant condition	s contributing to d	leath but not res	sulting In the u	nderlying c	ause giv	en in Pert I.						
_										1 L Y	98 2EJ NO	3 L Pro	Dauty 4 🖭 U	
										24a. Was a	n autopsy	24b. W	ere autopsy fin	
_									_	perform	11 <del>9</del> 0 /	co	mpletion of cat deeth?	
										10/10	s 2 No	Ji.	Yes 2 N	
25.	Was cese refer	red to medicel						26. Place of	Death (C	heck only on	е)			
	examiner?  X Yes 2	No	Hospital:	Inpatient 22	ER/Outpatier	t 3 DC	OA Oth	00				ner (Specia	(y)	
	Menner of Deat		28a. Date	of Injury oth, Dey Year)	28b. Time of	2	8c. Injur Wor	y at		1		4.4		
	1 Naturel Accident	5 Pending investiga	ation $8-3$	1-98	2140			Yes 2 2 No	n	votor u	ehrcle	colli	rollion	
	3 Suicide 4 Homicide	6 Could no determin	led 280. Plac	e of Injury - At h	nome, farm, str	et, factor,	, office		28f.	28f. Location (Street end Number or Rural Route Number.				
						stree				Pultr	more,	My		
298	a. Certifier (Check only	1 Certifying 2 Medicai E	xaminer: On the b	asis of examina	owledge, death ation end/or in	occurred vestigation	at the tir , in my o	ne, dete and p pinlon, death o	lece, and occurred a	due to the ca	ause(s) and m ate end place,	anner as s and due t	tated. the ceuse(s)	
201	one) b. Signature end	Λ	and mar	nner stated.				e number						
29t	J. Signature end	C Certiner	101			250		C.M.E.						
-	Na	uni ,	4 Chul	- as		2111								
30.	Neme and addr	ess of person by	no completed cau	•										
31	Date filed (Mon	th Day Year)	hute 11	Registrar's Sign	ature 11	1 Per	n S	treet,	Balt	imore,	Maryl	and 2	1201	
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			/		/ .	100	ack	21						

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			State of Mary		ertificate of			leg. No.	1100				
	Dhysisian	1. Decedant's Nama (First, Middla, L.					2. Dete of Dee	ith	Year	3. Tima of Dea			
	Physician /Medical	ETHEL	MARIE	TF	INNER		AUGUS			2:11	PM		
7	Examiner	4e Facility Name (If not institution, gi Saint Joseph	Medical Co	enter		4b. City, Town, or Lo				more			
	Funeral Director		Sex 7. Age (find 1) 7. Age (fi	In yrs. lest birthdi Yrs.	Months Days		8. Date of Birth (Month, Day Feb. 7	Year) 1920		laca <i>(Stata or Fo</i> <i>try)</i> yland	oreign		
	show	10e. Stata 10b. County		Oc. City, Town or	Location				10	0d. Inside City L			
	with the Mar t or 28s-f s be notified Director	Maryland Balti	more	Towson	10f. Zip Code			10g. Citizan of What Country?					
	23a or	8219 Carrbridge	Circle		21204			U.S.A.					
Maryland 21215-0020	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23a or 23s-f show ha Medical Earning must be notified a morpleted by Funeral Director	3ÅD Widowed 4 □ Divorced	12. Was Dacedant Eva Armed Forcas? 1 Yas 22 No If Yaa, Giva Yaar or Datas:	1 ☐ Yas 2♥ No If Yaa, Giva 1 ☐ Yas 2♥ No Specify:					, White, a	an Indian, atc. ite			
2-0	natural'.	15. Decedent's E (Specify only highest gr	ducation ada complated)	16a. De	cedent's Usual Occu iva kind of work done a. DO NOT usa retire	ng	16b. Kind of Bus	sinass/Ind	lustry				
121	ed within 72 hor or then "natural, t, the Medical Completed	Elementary/Secondary (0-12)	Collaga (1-4or 5+)		a. <i>DO NOT</i> usa <i>retire</i> ne Maker	ed)		Own H	omo				
102	High Co		t)		.o Hanci	18. Mothar's Nema	(First, Middla,						
/lar		Nelson R. C	Coleman			Mattie	C. S	Shaw					
Man	2 sh end end end	19a. Informant's Name/Relationship		I Route Numbe	r, City or Town, S	Steta, Zip	Code)						
	1 and 16aith 7 27 ther to	Edward J. Tanner,	Hunt Date	sville,	Al.	35801							
Baltimore,	Peges nent of i	1 Burial 2 Cramation 3 4 Donation 5 Other (Speci	Trientoverition State		sposition (Nama of tramatory or other ple		_	lew Free			lvan		
altir	artin Inju	21. Signature of funeral Sorvice Lice		New Fre	edom Ceme 22. Nama and Addra		98				Lvan		
Ö	Deg in a	1 50 17	land		Ruck Tows	on Funeral	Home.			rk Road	0.4		
		23e. Pert . Enter tha disaase or con shock, or haart failura. List only	ngications that crused the							Approximata tntarval Between			
	Physician		RESPIRAT							Onset and Deat	th		
	/Medical Examiner	Immediata Ceusa (Final disaasa or condition resulting in death)  Due to (or as a consequence of):											
L						TRESS SY	NDROME		1	DAYS			
	agecuted n and sel-transit Examiner	Sequentially list conditions,			T								
09	E Company	Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disaasa or injury		DAYS									
687	olbe	that initiated evants rasulting in deeth) Last	Due										
Box	S S		d										
	the attend the for united for uni	Pert II. Other significant conditions	contributing to death but n	ot resulting in the	a underlying causa gi	van in Part I.	23b. Dfd t	23b. Did tobacco use contribute to the cause of c					
P.0	requires that the death can een signed by the attention hould be deteched for un	RENAL INSUFF			101	1 Yes 2 No 3 Probably 4 July							
	be d						041 111000		0.45 14/4	sa autoon finds	lin on		
Records,		CORONARY ART	ERY DISEAS	SE			24a. Was a	med?	COL	ara autopsy finds allable prior to apletion of caus			
Re	has pe 2						101	es 2 <b>X</b> No		death?			
ta	delan: The certificate rector, pag	25. Was casa refarred to medical				26. Place of Death			1 [	J Tes 2LONO			
of Vital	7 a b	axaminar? 1 ☐ Yas 2☑ No	Hospital:	2 ER/Outpat	tient 3 DOA Ot	hor		ence 6 Otha	r (Specify	1)			
	on: ]	27. Menner of Death 1 ☑ Naturel 5 ☐ Pending	28e. Date of Injury (Month, Dey Ye	ear) 28b. Time Injur	y Wo		28d. Describe h	ow injury occurre	ed				
Division	Attending or death. ector: After fune by the fune iffication	2 Accident invastigation 3 Suicida 6 Could not to	Yas 2□No	28f Location /5	treet and Number	or Or Pura	I Davida Numbar						
≥ O	xeec t	4 Homicida datamined	28e. Pleca of Injury building, etc. (5		City or Tow		or riora.	THOUSE THEIR ST.	,				
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Cartiflar  (Check only one)  1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, end due to the ceuse(s) end menner as steted.  29a. Cartiflar  (Check only one)  1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and place, end due to the ceuse(s) end menner as steted.  20 Medical Exammer: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, end due to the ceuse(s) end menner as steted.  20 Medical Exammer: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, end due to the ceuse(s) end menner as steted.											
	within To the compl	29b. Signatura end titla of certifiar 29d. Data signed (Month, Day, Year)											
		Michard	r. My	Ticum	_ D 31	826		8-31	7-9	8			
	5	30. Nema and addrass of person who complated causa of death (Item 23a) (Typa, Print) RICHARD L. LINTHICUM, M.D., 7620 YORK ROAD TOWSON, MARYLAND 21204											
	State Registrar	31. Data filed (Month, Day, Year) SEP 0 3 199	32 Registrar's		Ana 1								

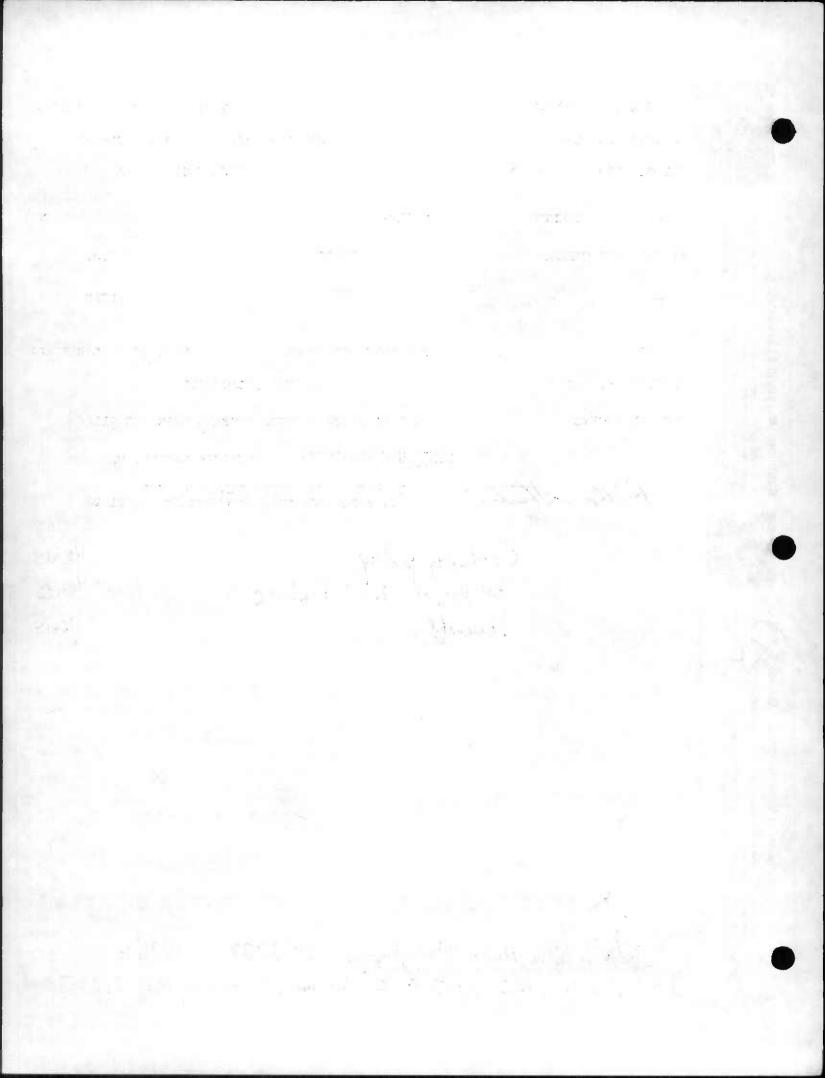
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					Cei	rtifica	te of	Death			Reg. No.				
	1. Decedent's Nama (F	irst, Middla, La	st)							2. Data of Dec	Data of Deeth Month Day Yeer  3. Time of				
Physician /Medical	SHIRLEY O	G. THOM	AS							AUGUST			5:2	27PM	
Examiner	4e Fecility Neme (If no		e street and number	er)				4b. City, Tov	vn, or L	ocation of Deeth	4c. Count	y of Death			
	GENESIS ELI	DERCARE						SEVERN		ARK	ANNE	ARUNI	DEL		
Funeral Director	5. Social Security Number 713-01-0839		ex	Age (In yrs. 88	last birthday) Yrs.	If Unde Months	Deys	If Undar 2 Hours	Min.	8. Data of Birt (Month, De 01/14/1	h V. Yeer) 19 <b>1</b> 0	9. Birthpl Count PA	ace (Stet try)	ta or Foraig	
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the Marylar 28a-f ahow nour ed rector		b. County	ED	10c. CI	ty, Town or Lo							10		City Limit	
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ath v	51 SAN REMO	CIRCLI					33962			W M	14 De	U.S.A.			
72 hours efter death with the Maryland naturel; or items 23s or 28s-f show death or items be notified as the by Funeral Director	11. Maritel Status 1 □ Naver Married 3 ☑ Widowed 4 □		12. Was Decede Armed Force 1  Yes 24 If Yes, Give Yaar or Deta	s? XNo				en, Mexican, Specify:	in r (Sp , Puarto	ecify Yes or No- Rican, etc.)	14. Race - American Indian Black, White, etc.  Specify: WHITE			•	
72 ho	15 (Specify)	. Decadent's Econly highest gra			16a. Dece	dent's Usi	el Occup	oatlon	of work	cina	16b. Kind of E	Jusiness/Ind	lustry		
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should ind Men ind Men ind Men ind Men ind Men ind Men ind ind ind ind ind ind ind ind ind in	19a. Informant's Name	/Reletionship (	Type, Print)		19b. Maili	ng Addres	s (Street	and Numbe	r or Rui	rel Route Numbe	Code)				
1 and 2 s Health ar am 27 is other trau	SUE EVANS/N	NIECE			385	STONE	EHOUS	SE DRI	VE S	SEVERNA	PARK,	MD 213	L46		
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	21. Signature Funar			CR	EMATOR		nd Addre	ess of Fecility		3/31/30	DAOTOL	, 110			
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-	23e. Pert1. Enter the c shock, or haart fa	<b>4</b>	elications that save	and the dee						CATONSVI		D 2122		nate Between	
/Medical Examiner		lons,	e. Con c. Dei	Due to	or es e consecuence	teur quenca of	+ 7	Taylo	re			1	ye.	ars ears	
that the death confidence of by the etter confidence of the confidence of the confidence of Physician/Medical		L	d		or as a consec			ven In Pert I.		23b. Did	tobecco use c	ontribute to	the ceu	se of dea	
uires that the designed by the deteched by Physical by										10	Yes 2□ No	3 Prot	bably 4	Linkn	
been shoul										24e. Was parfo	en eutopsy rmed?	ave	ere eutop eilable pri mpletion daath?	sy finding ior to of causa	
The law ate hes page 2										10	Yas 200	10	Yes :	2□ No	
ysiclan: The I s certificate he director, page To Be Com	25. Wes case referred	to medical						26. Placa	of Dea	th (Check only o	one)			-	
Physician: this certific ral director, TO Be (	examiner?		Hospitel: 1   Inp	ationt 2	] ER/Outpetie	nt 3 🗆 🖸	OA OI			ome 5□Resi		thar (Snecil	iv)		
rthis eral di	27. Mannar of Death		28e. Date of i		28b. Time o		28c. inju Wo		omg (	28d. Describe			,,		
th. After stuner		Pending investigatio		Day Year)	injury	М		rk? ]Yes 2∐1	No						
To the Hospital or Attending Phwithin 24 hours effect death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	2 Accident Investigation 3 Suicida 6 Could not ba determined 28e. Placa of Injury - At home, farm, streat, factory, o building, etc. (Specify)													Vum <i>ber</i> ,	
To the Hospital within 24 hours to the Funeral completely filled	29a. Cartifiar (Check only one)		yeicien: To tha ba niner: On the bask end manner	of axamin										se(s)	
within 24 To the Fu Complete	29b. Signeture end title	of certific	) - Grid mariner	olarou.		2	c. Licen	se number			29d. Data sign	ed (Month.	Dey, Yes	ır)	
2348	NO.	47	60 117	DI	n. II D	11		Des	17	18	8/21	98			
6	Su	10 Mg	MANIP	- III	eveling ?	19844	1	NO	11	20	0/2/	10			
h	30. Name end eddrass	of person who	completed causa	of death (Ita	m 23a) (Typa,	Print)	15	11	D	11.1	417	711	22	_	
-	John	LOOMR	Mide	551	1-14	1417	me	truy	Do	elthor	E, MU	2/0	40		
State	31. Dete filed (Month, I	3 1998	Senser	istrar's Sign	d.	Som	11	ł			*				



**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mental Hygiena. Important: If item 27 Is merked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Eraning must be notified at once.

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

MARY ELIZ

Pleas ABETH TAYLOR	State of I		d / Depa		of H	lealth a		_		e d	<b>ble.</b> 2.6	966
1. Decedent's Nama (First, Middla,	Last)			Timouro	-	- Juli		2. Data of De	ath			3. Tima of Death
MARY ELIZABETH T	AYLOR							AUG.	31,	1998	Year B	2220 PM
4a Fecility Nama (If not institution, § 331 WESTSHIRE		er)				4b. City, Tov		cation of Deat	-	c. County		
5. Social Security Number 200–07–3101	V	Aga (In yrs. 38	last birthday) Yrs.	If Undar 1 \ Months D	Yaar Days	If Under a	Min.	8. Date of Bir (Month, De JUNE 2		1910	Coun	lece (State or Foraign try) SYLVANIA
Usual Rasidence of Dacedant  10a. State 10b. County  MD BALTIMO	RE		y, Town or Lo								10	0d. Inside City Limits 1 ☐ Yes 2 No
10e. Street and Numbar 331 WESTSHIRE RO	AD			10f. Zip Co					100	citizan of \	What Coun	try?
11. Marital Status  1 Navar Marriad 2 Married  3 X Widowad 4 Divorced	12. Was Decede Armed Force 1 Yas 2 If Yas, Giva Year or Data	s? ∑No		Was Decedan If Yas, specify 1 ☐ Yas 2X	Cubi	Ilspanic Orlg an, Maxican Specify:	in? (Spe , Puarto	ocify Yes or No Ricen, etc.)	0-		e - Americ ck, Whita, v: WHI	atc.
15. Decedant's (Specify only highest Elementary/Secondary (0-12)		or 5+)	(Give lifa.	dant's Usual C kind of work of DO NOT usa r	dona ratire	during most d)					D OF	EDUC.
17. Fathar's Name (First, Middla, La JAMES BRINDLEY						18. Mothe		(First, Middle	, Maid		ne)	
19a. Informant's Name/Relationship CAROL L. TAYLOR  20a. Mathod of Disposition 1 □ Burial 2 ☑ Cramation 3	DAUGHTER		1260	ng Address (S CARLA sition (Name matory or otha	ND of	PLAC			MD	2070	_	
4 Donalion 5 Other (Spe  21. Signatura Funaral Sarvica Lic  23a. Pert1. Enter the diseesa, or or shock, or heart failure. List or	Lansee Lenner of the Company of the	mer sed tha daat	10	E WASHI 2. Nama and A 630 EDM tar tha mode o	Addra 10N	nss of Facility	WI'	TZKE F	UNEI SVII	RAL H	IOMES,	
Immediata Causa (Final disaasa or condition resulting in death)	a. Arter:	ioscle	erotic	Cardio	va	scula	r Dis	sease				
	b	Dua to (d	or as a consa	quanca of):							1	
Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Causa (Disease or injury that initiated evants rasulting in death) Last	c		or as e conse									
lasuning in daam) Last	d											
Part II. Other significant conditions	contributing to deat	n but not ras	sulting in tha u	inderlying caus	sa gi	van in Part I				co usa co	3 Pro	the cause of death?
								24a. War peri	ormed	?	av	ara autopsy findings ailabla prior to mplation of causa death?
								1 🗆	Yas	2 💢 No	10	Yas 2□ No
25. Wes casa referred to medical axaminar? 1XX es 2 □ No	Hospital:	atient 2	] ER/Outpatie	nt 3□ DOA	Ott			ma SARes		6 □Oth	nar (Specif	y)
27. Mannar of Death  1 XX atural 5 Panding 2 Accidant invastiga	28a. Data of I (Month,	njury Day Year)	28b. Tima o Injury	of 28c.	. Inju Wo 1 □	ryat rk? ∣Yas 2 🔲		28d. Dascribe	how in	jury occur	rred	
3 Suicida 6 Could no 4 Homicida datarmin	be d 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number of City or Town, Stata)								al Route Number,			

**Physician** /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires that the death certificate Deposecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funeral director, page 2 should be dateched for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State

Dennis Chute M.D. 31. Data filed (Month, Day, Year) SEP 0 3 1998

30. Nama and addrass of person who comp

29b. Signature end title of certifier

29a. Cartifiar (Check only one)

32. Registrar's Signature

d causa of daath (Itam 23a) (Typa, Print)

111 Penn Street, Baltimore, Maryland 21201 souls

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licanse number

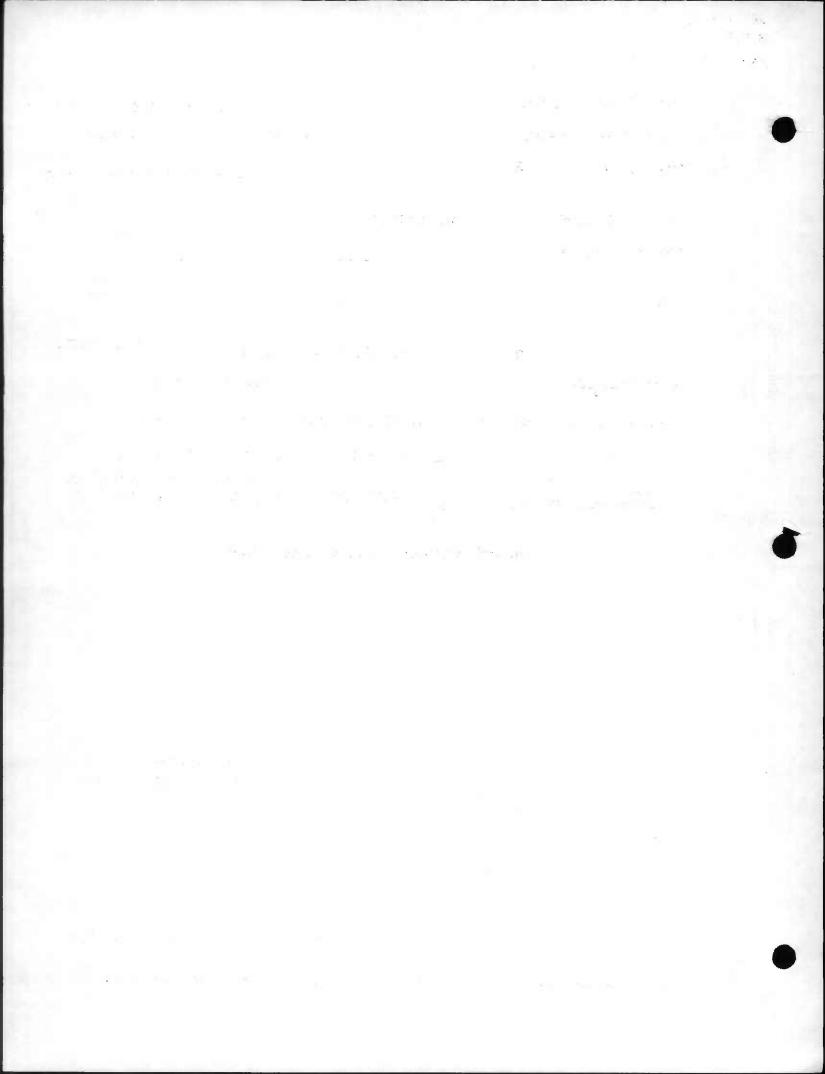
O.C.M.E

29d. Date signed (Month, Day, Year)

AUG.

31, 1998

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

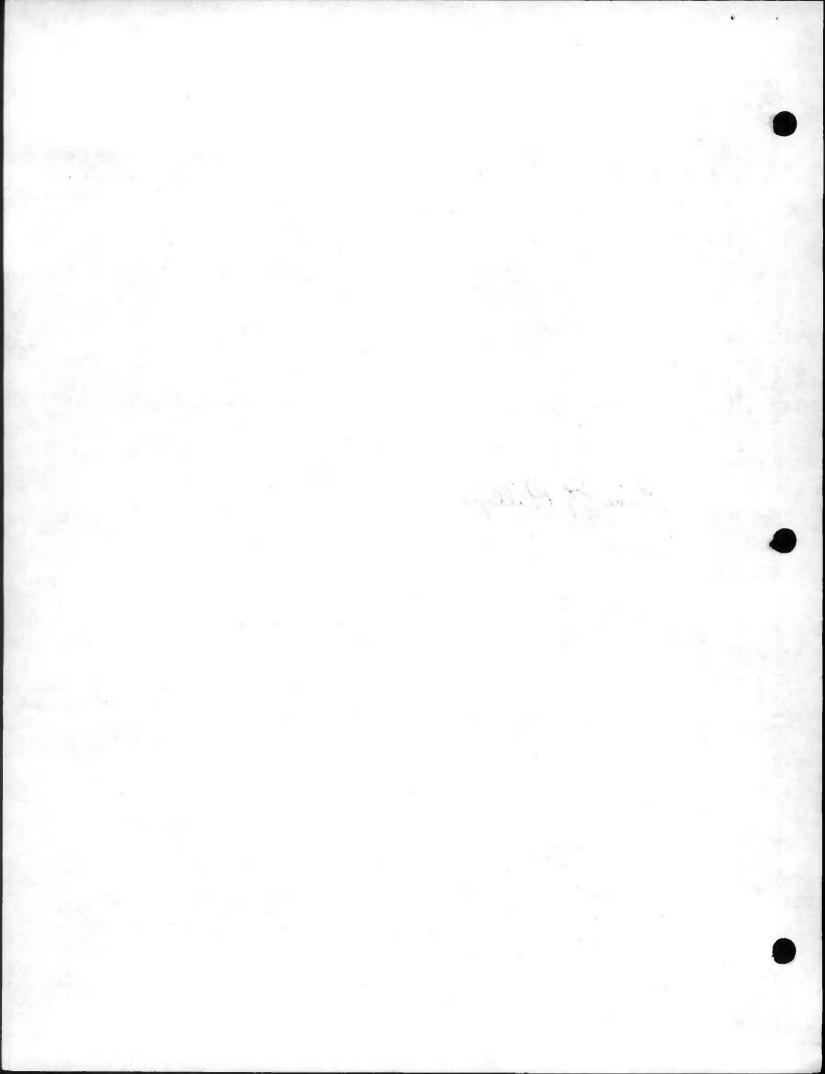
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dala of Death 3. Time of Death Month Year Physician ERA WATKINS AUGUST 26 12:37 PM 1998 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner HARBOR CENTER BALTIMORE HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Birthplaca (State or Foreign Country) 1 M 2 F Days Months 213-34-7532 Director 62 June 19,1936 North Carolina Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location Baltimore "natural", or frame 23a or 28a-f show 10d. Inside City Limits Md. Baltimore Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 2448 Nevada Street USA Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2章 No If Yas, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Martial hygiene. Important: if Ikem 27 la marked other than "naturally hijury or other traumatic event, the Medical pages. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence Allen Ada Chestnut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2448 Nevada Street Baltimore, Md. 21230 Neal H. Watkins 20b. Place of Disposition (Name of cemetary, crematory or other place)
Garrison Forest Vet. Cem. 9/1/98 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Loudon Park Funeral Home 3620 Wilken Ave Baltimore 21. Signature of Funeral Service Licenti Maryland 21229 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HEPATO RENAL SYNDROME 3 DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner 3 DAYS Shystolan and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury Due to (or as a consequence of): 5 MONTHS Box 68760. METASTATIC COLON CANCER that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the deeth cartified USB P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Records, ò 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed' 1 Yes 20 No 1 Tyes 2 TUNE Division of Vital or Attanding Physician: 25. Was case referred to medical 26. Placa of Death (Check only one) To. Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred edical Certification: After 5 Pending investigation 1 ONatural death. 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ofter 4 ☐ Homicide To the Moepital o within 24 hours aff To the Funerel Di completaly filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number guela duritz 26 1998 OFFICER AUGUST HOUSE P10647 R 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURTHY MO 21225 3001, S. HANOVER STREET, BALTIMORE ANGEETHA 31. Date filed (Month, Day, Year) SEP 0 3 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

State Registrar



JOSEPH S. WALKER

1. Decedent's Name (First, Middle, Last)

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0

Certificate of Death

2. Dete of Deeth

4c. County of Death

CARROLL

U.S.A.

14. Rece - American Indien, Black, White, etc.

Guard

21228 Approximete Intervel Between Onset and Deeth

Specify: white

3. Time of Death

Birthplece (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

1755 PM

30, 1998 eer Month AUG. **Physician** Joseph Salvatore Walker /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) Examiner 807 VELVET RUN DRIVE WESTMINSTER If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdev) If Under 1 Yeer 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1⊠M 2□ F Director 066-48-8968 Jan. 6, 1954 New York Usual Residence of Deceden the Maryland 10c. City. Town or Location 10a Stete 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Westminster MD. Carroll Director 10a. Citizen of Whet Country? 10e. Street end Number 10f, Zip Code 21157 807 Velvet Run Drive Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus nit. Pages I and 2 should be filed within 72 hours after of erment of Heelih and Mental hygiene. ortant: If Item 27 is merked other than "natural", or Item Injury or other traumatic event, me Medical Emantine. 1 ⊠Yes 2 □ No
If Yes, Give
Yeer or Dates: Desert 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify: p 3 Widowed 4 Divorced Storm Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry MD. National Air Elementary/Secondary (0-12) College (1-4or 5+) Avionics Technician 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Rose Scimeca Joseph Daniel Walker 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 807 Velvet Run Dr., Westminster, Md. 21157 Jeanne Kennedy Walker, wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9/6/98 Depertment of Important: If any Injury or Laurel, Md. Baltimore/Washington Crematory 22. Name end Address of Fecility 21. Signeture of Funeral Service Licenses Witzke Funeral Home, INc. 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final HANGING disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of): physician and Box 68760 Physician/Medical the Due to (or es e consequence of) 80 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 8 à sign Completed peen hes page 2 certificate Division of Vital or Attanding Physician: director. 25. Was case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) XXYes 2□ No 2 this 28b. Time of funeral 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth Certification: After 1 Neturel 5 Pending FOULD & 3048 HOUND 1600 M efter death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 30XSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide RESIDENCE 24 hours Hospital 1 Cartifying Phyalcien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted.

XXMedical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted. edicai 29a. Certifier completely (Check only one) within 2 the 29b. Signature end title of certifier 29c. License number 0 O.C.M.E

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? I'M PEUTO 1 Yes 2 No 1 ☐ Yes 2 ☐ No 28d. Describe how Injury occurred Substitution ser. 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 807 VELVETRUNDR. CARPOLL CO. 29d. Date signed (Month, Dey, Year) AUG. 31, 1998 111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Day, Year)

mes

Margarita Korell M.D.

32 Registrar's Signature

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

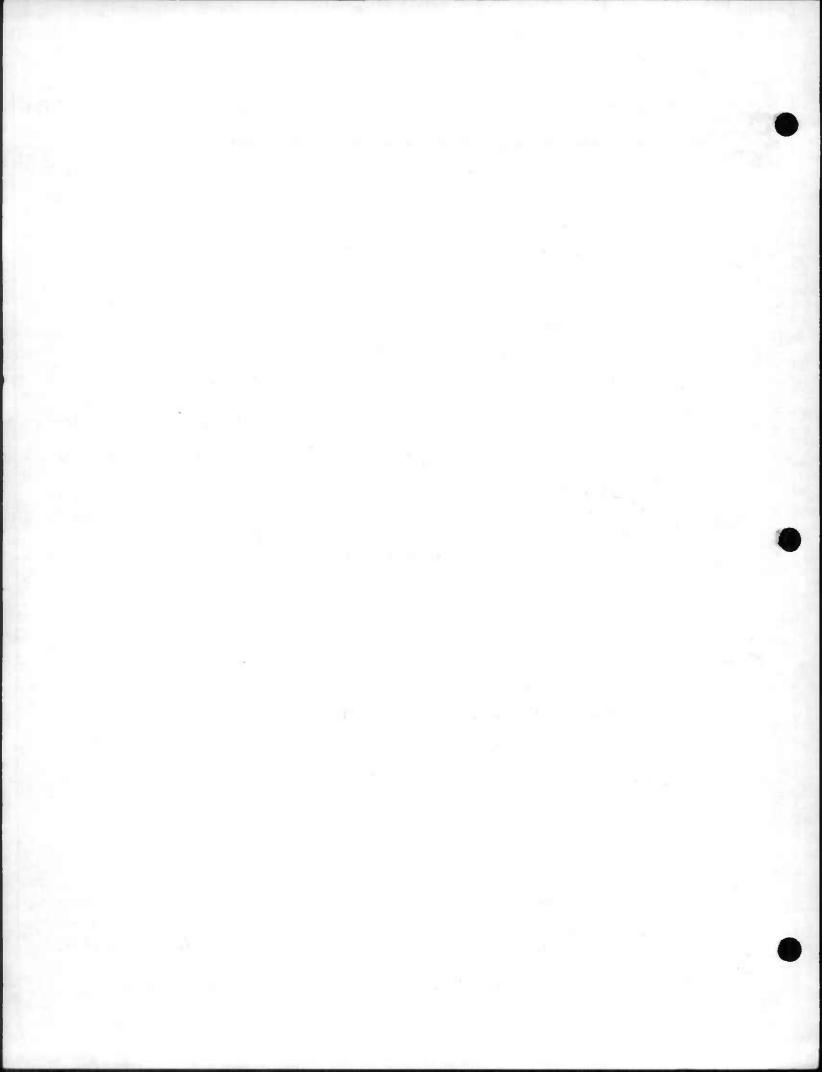
Registrar

State



State of Maryland / Department of Health and Mental Hygiene

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erai etor		5. Social Security Nu 230-70-822 Usual Residence of I	20 1	CINA ONLE	48	Yr.	Month			Min. 12	ate of Birth fonth, Day, -09-19	949 V	9. Birthpi Count Iest V	ece (State or Foreign try) /irginia
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any injury or other traumatic event, the Medical Examinet, must be notified at once.  To Be Completed by Funeral Director		Maryland	N/A		Ba	ltim	ore							1 Ves 2 No
Dire		10e. Street end Num						Zip Code			10	g. Citizen of V		try?
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by Funeral	•	11. Meritel Stetus 1 ☐ Never Merrie 3 ☐ Widowed 4		12. Was Deceder Armed Forces 1 Yes 2 1 If Yes, Give Yeer or Dates		J,S.		2 X No	Hispanic Originan, Mexican, Specify:	n? (Spacify Y Puerto Rican	es or No-		e - Americe ek, White, e	etc.
eted	I	(Snecit	15. Decedent's Ed y only highest gre	ducetion		16e. D	ecedent's U	suel Occu	petion	of working	1	6b. Kind of Bu	siness/Ind	ustry
Completed	-	Elamantary/Secon	dary (0-12)	Collaga (1-40)	5+)		emaker		during most o	n working		Own Hor	ne	
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P P	-		asnick						Doroti	hy Fay	e Tay	lor		
		19e. Informent's Ner David M. I							t and Number					Code)
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	-	21. Signature of Fun			Mem	ory (			ess of Fecility	9-4-		tauntor Ruck,		rginia
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	+	239 911	disease or com	Wayne Os	terli	ng l	5305 F	larfo	rd_Road	d Bal	timore	e, Mary		21214 Approximate
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Physician/I														
d by Physicia	1	Pert II. Other eignific	ent conditione o	ontributing to death	but not res	ulting in th	e underlyln	g cause gi	iven In Pert I.	4	23b. Dld tot	Dacco uee col	ntribute to	the cause of death?
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ToB		examinar? 1 ☐ Yes 2 💢 N	lo	Hospitel: 1 Inpai	tient 2	ER/Outpo	atient 3	DOA Ot	har			nce 6 Oth	er (Specify	)
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atic		1 Neturel 2 Accident	5 Pending investigation		.,,	li ijo	M		Yes 2□No	0				
T E		3 ☐ Suicide 4 ☐ Homicide	6 Could not be datarmined	289. PIECE OF II	njury - At h	ome, ferm	, street, fect	ory, office		28f. Lc	ocation (Str.	aet and Numb Stata)	er or Aural	Route Number,
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edical Certification:		29e. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the bes niner: On the basis	of examine	owledga, detion end/c	aath occurre r investigeti	ed et the ti	ime, data end oplnion, daeth	place, end du occurred et l	ue to the ce the time, de	usa(s) and ma te end piece,	nnar as sta and due to	atad. tha ceuse(s)
We Me	1	29b. Signature end ti	tle of certifier	end mennar s	tatao.	-	T	9c. Licen	se number		29	d. Dete signe	Month F	Day Year)
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Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Aug. 31 1998 9:35 PM Clara Walker 4e Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hamilton-Genesis Elder Care Baltimore, Md. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Novith, Day, Year) 00 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 M 2 N F 97 217-01-2963 Yrs Usuet Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1' Yes 2 No Baltimore, Md. NA 10f. Zip Code 10e Street and Number 10g. Citizen of Whet Country? 21213 USA 3021 Kenyon Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritat Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ⊠Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Cotlege (1-4or 5+) Clothing Mfg. 6th Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Paul Walker Clara Schieffle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ratationship (Type, Print) 6105 Fair Oaks Ave. Baltimore, Md. Evelyn M. Smith/Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National 9/3/98 Baltimore 22. Name and Address of Facility.
Hartley Miller Funeral Home, CHTD. 21. Signature of Funeral Service Incenses 7527 Harford Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate tntarvat Batween Onset end Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wera autopsy tindings evaitable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Pending investigation 1. Natural 1 ☐ Yas 2 ☐ No

Examiner Physician/Medical Box or Attending Physician: The law requires that the death Records, P.O. signed b þ Completed Division of Vital Be Certification: To this After

**Physician** 

/Medical

Examiner

Director

Funeral

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Director

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Registrar

**DHMH 16 Rev 6/95** 

State

Medical

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of certifier

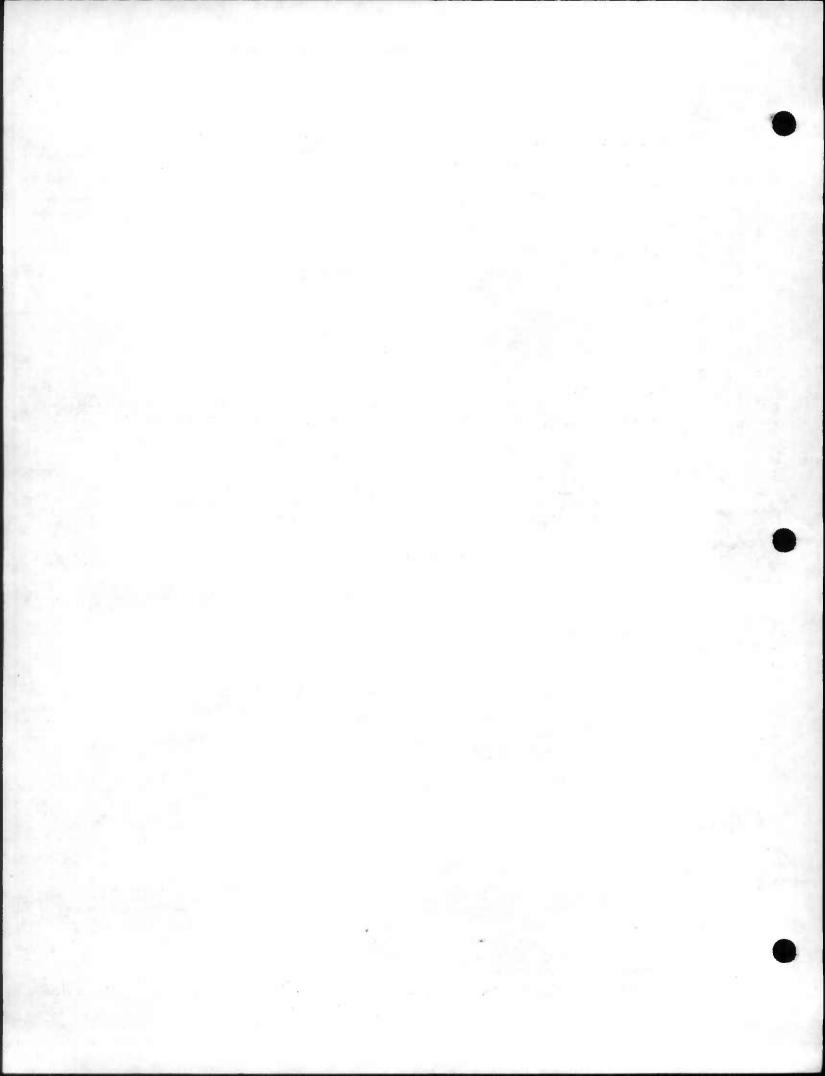
28e. Piece of fnjury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Brehms Lane 3400

VANIK 32. Registrar's Signature

6 Could not be detarmined

Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death Month ember ances 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give streat and number) FMORE and If Under 1 Year If Under 24 Hrs. 8. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1□M 2XF Days 220-20-564 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No more 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Ve 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: 3 ₩Widowed 4 Divorced 4+10-Hmerican 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usp retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumama) rene ini) (daughter) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Placa of Disposition (Nama of comptary, gramatory or other place) riumphrey Md. 20b 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Spacify) to 22. Name end Address of Facility 21. Signature of Funeral Service)Licenses Home Joseph 2222 1 tuneral 1. Enter the fisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, k, or heart, filure. List only one cause on each line. 21216 Approximate Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting In death) Last Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cauea of death? 1 ☐ Yes 2 ☐ No 3 □ Probably 4 ☑ Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 0 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Locetion (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide

/Medical Examiner and physician Division of Vital Records, P.O. Box 68760 8 has

Examiner the buriel-trensit Physician/Medical usa þ Completed To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be Certification: To Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours aftar death w. Department of Heath and Mental Hygiena. Important: if item 27 is marked other than "netural", or items 23a any Injury or other treumatic evant.

**Physician** 

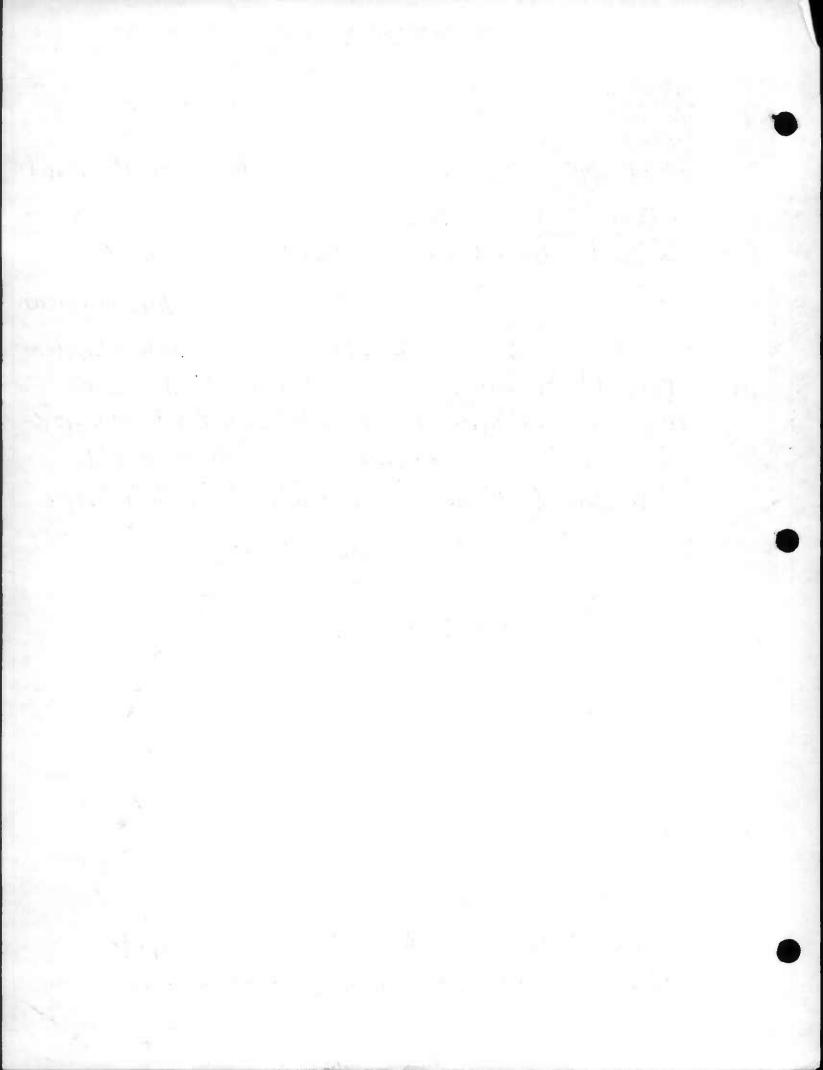
Registrar

29a. Certifier

(Check only one)

2 Medical Examinar: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Yeer) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature SEP 03

1 🗘 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3 Certificate of Death 2. Data of Death 1. Decadant's Nama (First, Middla, Last) 3. Tima of Death Year **Physician** YANKOFF LESTER. 1998 6:42 AM SEPT /Medical 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner JEWISH CONVALESCENT HOME BALTIMORE BALTIMORE If Undar 24 Hrs. If Undar 1 Yaar Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Months 10M 20F 79 Yrs. Director MAR 24, 1919 MARYLAND 219-07-2723 Usual Rasidance of Dacedant with the Manyland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County than "natural", or items 23a or 28s-f show the Medical Examiner name be notified at 1 Yas 2 □ No MD BALTIMORE OWINGS MILLS Director 10e. Street and Number 10g. Citizan of What Country? 10f Zip Code 9318 GROFFS MILL DR. 21117 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. filed within 72 hours after 1 Navar Marriad Marriad Tyas 2 ☐ No Yes, Giva 1 ☐ Yas 2 ☐ No Specify: Specify: WHITE þ 3 ☐ Widowad 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Hygiena. Elementary/Sacondary (0-12) Collaga (1-4or 5+) SALESMAN CLOTHING 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth Be ANNA **JACOBSON** LIPMAN YANKOFF 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) GERTRUDE YANKOFF (WIFE) 9318 GROFFS MILL DR. OWINGS MILLS, MD other 1 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition Deta 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State = 8 permit. Page Department of Important: if any injury or once. 9/2/98 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN BALTIMORE, MD 21. Signatura of Funara Lice 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1. Enter the disease, of complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or head initiae. List only one ceuse on each line. **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in daath) MYOCARDIAL INFARCTION Examiner Dua to (or as a consaquance of): Examine HYPERTENSION Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Dua to (or as a consequence of): ATHEROSCLERSTIC HEART DISEASE edical Dua to (or as a consequence of) Physician/M CHRONIC RENAL FAILURE 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown DEGENERATIVE JOINT DISEASE þ 62 24b. Wara autopsy findings available prior to 24e. Was an autopsy Completed SLEEP APNEA completion of cause of daath? page 2 768 1 Yas 2 No 1 ☐ Yas 2 ☐ No 818 25. Was cesa rafarrad to medical axaminar? a 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yas 2 No Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) this . fumeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No after deat Director: 6 Could not be 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 孟 4 Homicida 6 24 hours Funeral 10 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier edical (Check only one) Within 2 To the 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifiar 9/1/98 D 30339

State Registrar

MILAN WISTER, 31. Data filed (Month, Day, Yaar) SEP 0 3 1998

MD 4000 OLD COURT RD. 32. Ragistrar's Signature

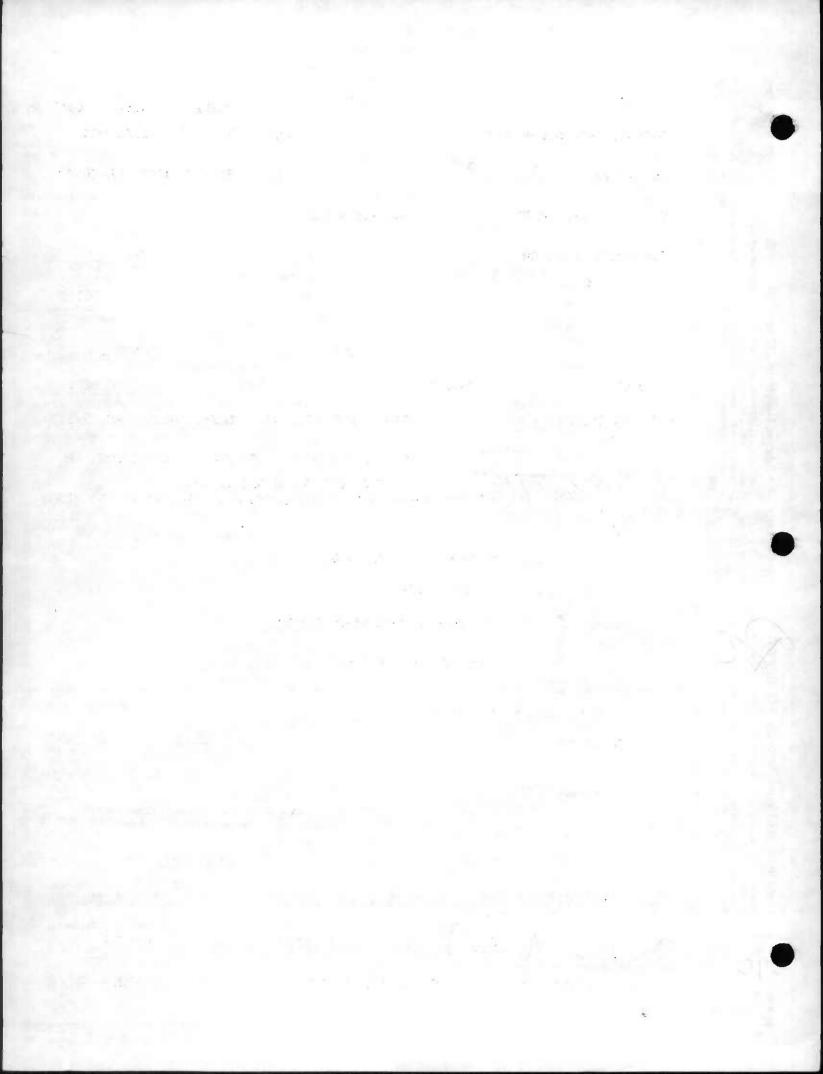
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Baltimore, Maryland 21215-0020

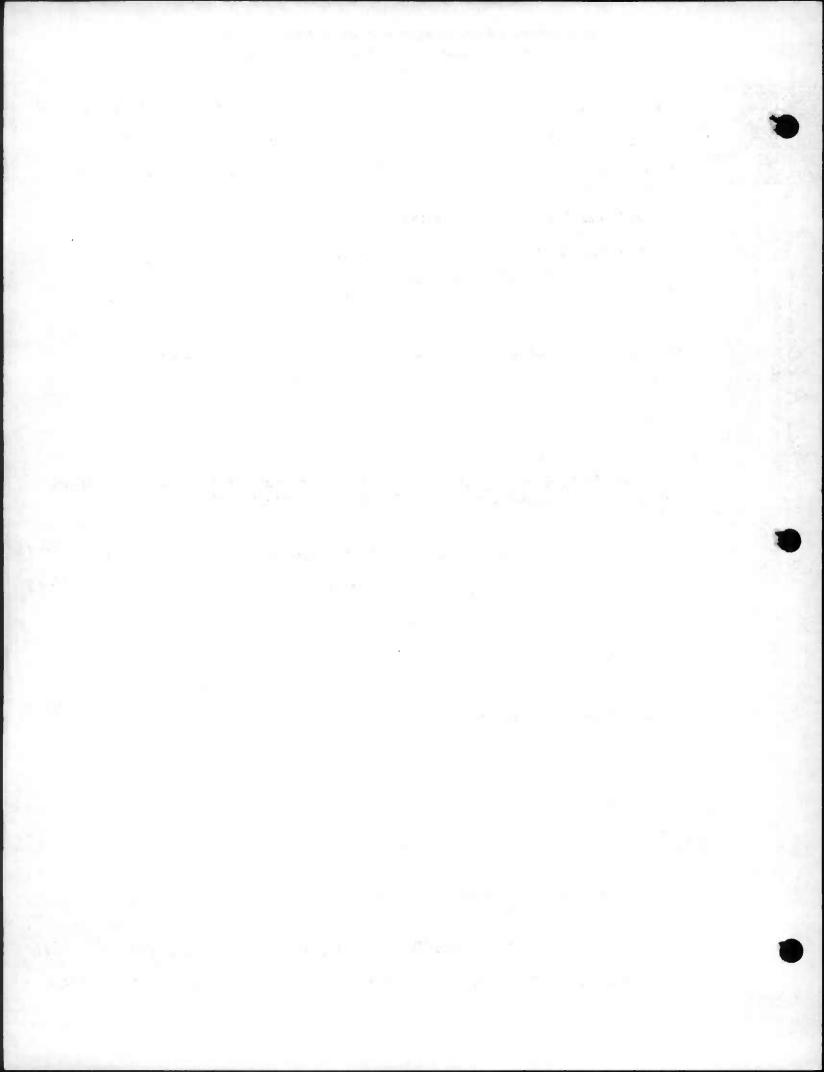
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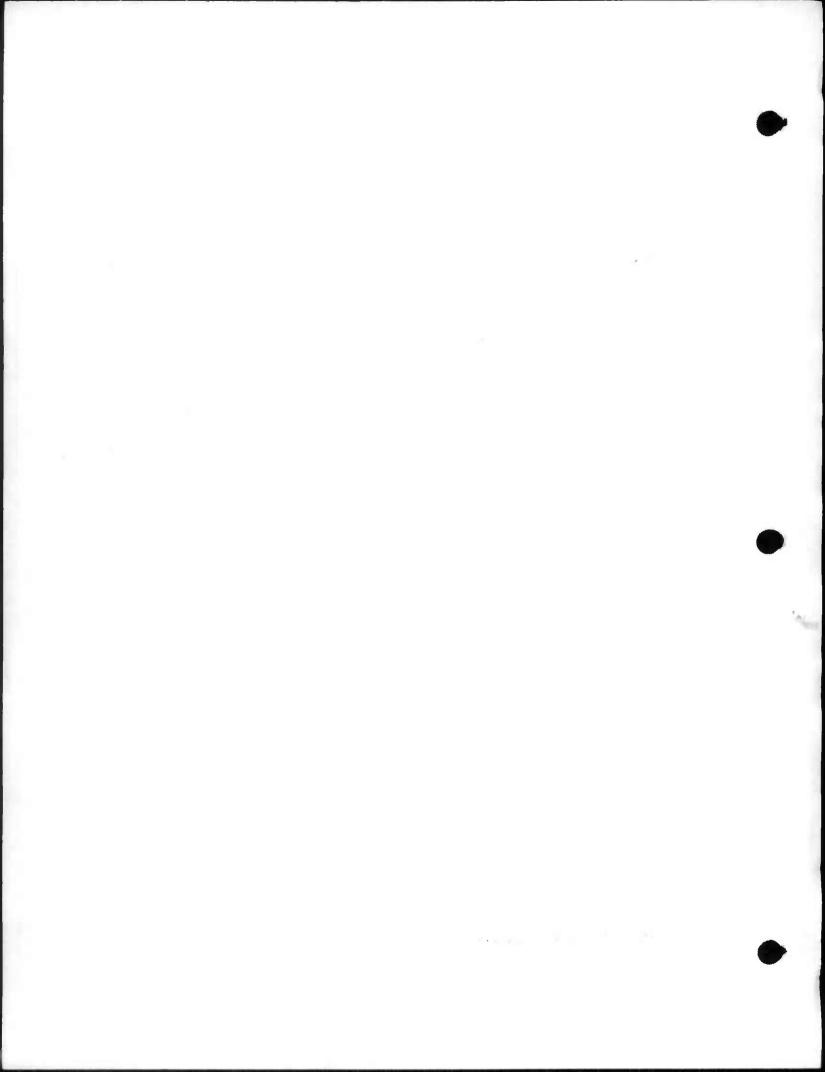


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhers hours after death. Page 6 may be retained by the hospital or attending physician.

		1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		IENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)	ATILDA ELI	ZABETH	ASPLE	N	2. DATE OF DEATH DO AUgust 20		3. TIME OF DEATH 12:25 p M
D		4. SOCIAL SECURITY NUMBER 218-34-9478	5. SEX 6. AGE (III	yrs. lest birthday) YRS.	F UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) Oct. 26 1	8. B	IRTHPLACE (State or Foreign outly)  laryland
2, 3 should	OR	9a. FACILITY NAME (If not institution, give str Glasgow Nursing				Cambridge		9c. COUNTY C	chester
. Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  MD  10b. COUNTY  DOT	chester	10c. CITY	, town on locat	bridge			10d. INSIDE CITY LIMITS?  1 YES 2 NO
burial-transit permit.	FUNERAL	100. STREET AND NUMBER 311 Glenburn Av	e.		101	21613		U.S.	OF WHAT COUNTRY?
the the	BY	1   Never Merried   Merried   S   Widowed   4   Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	€ <del>  110</del>	If yes, sp	ENDENT OF NISPANIC ecity Ouban, Mexican, 27 NO Specify:	C ORIGIN? (Specify Yea Puerto Rican, etc.)	1 1	RACE — American Indian, Black, White, atc.
ed for use as	COMPLETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)		Ille. Do NOT usi	ork done during mo	ON st of working	16b. KIND OF BUS		
5 should be detached for notified at once.	ш	17. FATHER'S NAME (First, Middle, Last) Samuel T	imothy Bell				E (First, Middle, Maiden	0,	Spicer
e 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print) Kenneth R. Asplen	- son	195. MAILING 1650 T	ADDRESS (Street a	nd Number or Rural Ad Island Rd	• Woolfo:	n, Stete, Zip Code rd MD 2	))
irector, page r must be	-	206 METHOD OF DISPOSITION 1   Burlet 2   Cremation 3   Ramor	val from State Carne OI	PLACE AND DATE O stery, cremetory of off C Trinit	FDISPOSITION (Ne		OATE 20c. LO	cation – city o urch Cr	
he funeral dii Pal. I examiner		21. SIGNATURE OF FUNERAL SERVICE LICE	Thomash.		Thoma: 700 L		Home PA Cambridge		613
inding physician and completely filled in by the funeral director, page Hyglene prior to burial, cremation, or removal, or other traumatic event, the medical examiner must be or other traumatic avent, the medical examiner must be	CATION	23. PART I. Enter the diseases, or combook, or heart failure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING	ist only bna cause on each	pulve consequence of	i hein		an cardiac or reepi		Approximate interval Between Onset and Death Mary
	CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	Perfer	CONSEQUENCE OF	exul	n dis	em		month
certificate has been signed by the att the State Dept, of Health and Menta 1, or Item 23 shows any Injury,	MEDICAL	PART II. Other aignificant conditions					PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 ND
icate has b State Dept.	SICIAN:			6. PLACE DF OEAT	N (Check only one) OTHER:				
wit ke	ву рну	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJI	e 5 Residence 8 URY AT RK? 'ES 2 NO	Other (Specify)  28d. DE\$CRIBE HOW IF	JURY OCCURED	)
after d	ETED E	3 Suicide 8 Could not be 4 Nomicide determined	28a. PLACE OF INJURY - building, etc. (Specifi	— At home, farm, st	treet, fectory, office		281. LOCATION (Street a City or Town, State)	nd Number or Ru	ral Route Number,
7 P = 1	COMPL		IAN: To the best of my knowle : On the basia of axamination						se(s) end menner as stated.
TO THE FUNER  De filed within 7  IMPORTANT:	TO BE C	30. NAME AND ADDRESS OF PERSON WHD	CDMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type,	Print)	29c. LICENSE NUMB	ER	29d. DATE SIGN	NED (Month, Day, Year)
		31. DATE FILEO (MONTH, Day, Your) AUG 2 1 1998	105 A P32 REGISTRAR'S SIGNAT	TURE	r Can	ismid	ge m	021	413.
		700 N + 1000		D. 1	an Val				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5 9 7 5

				,	(	Certifica	ate o	f Death		Reg. No.		
Physic	aian	1. Decadent's Nama (First, Middla, La	st)						2. Date of D		Yaar	3. Tima of Daath
/Med		Nancy Elaine	Mackie	Alli	ison				August	18	1998	15:55
Exam	iner	4a. Facility Name (If not institution, giv	ra straat and number	n				4b. Cify, Town, or		th 4c. County	of Daath	
		29 Willow Court				William	de a d Ve	Elkton		Cec		
Funera Directo	100	5. Social Sacurity Number 6. S	Sex 7. A	ge (In yrs.	last birth	Month	der 1 Yea is Day		. (Month, E	ay, Yaar)		aca (Stata or Foraig try)
		216-52-8702 Usual Residence of Dacedant		51					Februar	7 11, 1947	Mar	yland
yland		10a. State 10b. County		10c. Ci	ty, Town o	or Location					10	Od. Insida City Limits
the Maryland	ctor	Maryland Ceci	1		E1	kton						1 ☐ Yas 2XX No
th with the Mar 23a or 28a-f st	Director	10a. Street and Number				10f. 2	Zip Code			10g. Citizen of	Whet Coun	try?
23a		29 Willow Court					219	21		United	Stat	es
ter dea itams	Funeral	11. Marital Status	12. Was Dacedan Armed Forcas	t Ever in U	,S.	13. Was Dad If Yas, s	cedant of pecify Cu	Hispanic Origin? (Siban, Maxican, Puai	Specify Yas or N to Rican, etc.)	o- 14. Rac	ca - Amarica ck, Whita, e	
20 to 5	b	1 ☐ Navar Marriad 2 🛭 Marriad 3 ☐ Widowed 4 ☐ Divorcad	1 ☐ Yas 2 ☒ If Yas, Giva Yeer or Datas					o Specify:		Specif	Y 71	ite
15-00; 72 hours "natural;	Completed	15. Decadant's Ed (Specify only highast gra	ducetion		16a. D	ecedant's Us	sual Occ	upation	urkina	16b. Kind of B	usinass/Ind	ustry
2121 d within giene.	npie	Elamentary/Secondary (0-12)	College (1-4or	5+)	- li	fa. DO NOT	use ratii	e during most of wo rad)	ir Kii ig			
nd 212 e filed withi al Hygiene. other than	00	47 5-4-1-1-1-25 4 4444 1 4	4		Re	giste	red l	1		Hospit		
anc	Be	17. Fathar's Name (First, Middla, Last,						18. Mothar's Na		a, Ma <i>idan Suma</i> n	na)	
Aarylan 2 should be 1 end Mental is merked o	2	Henry McVey Mac			401. 6	4 - 101	(0)	Bernic				
Ma d 2 s th en T is 1								at and Numbar or R			State, Zip	Coda)
ore, Maryland 2 ss 1 and 2 should be filled of Health end Mental Hygic flem 27 is marked other r other traumatic event, the		David M. Allison 20a. Mathod of Disposition	/ Spouse	20b. F		W 1110V isposition (A crematory o		urt, Elkt	On, MD	21921 20c. Location -	City or To	wn State
Baltimore, Mippenit. Pages 1 and 2 Department of Health e important: if item 27 is any injury or other transones.		1 ☐ Burial 2 ☑ Cramation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Spacific		4					Aug. 21			
nit. F		21. Signature of Funeral Service Lices		<u>R.</u>	A. Fe	erris 22. Nama		ress of Facility	1998	West Ch	ester	Penna.
Ba perm Depa impo		11/09/1/	. //			Crouch	h Fu	neral Ĥom				
100		23e. Part1. Entar the disaasa, or com shock, or heart failura. List only	plications that cause	nd the deat	th Do not	127 So	outh	Main Str	eet, No	rth East	, MD	21901 Approximata
I Records, P.O. Box 68760, The law requires that the deeth certificate be executed at the bean signed by the ettending physician and page 2 should be detached for use as the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Entar Undertying Causa (Disease or injury that initiated events resulting in death) Last	b	Dua to (d	or as a cor	nsaquance o	of):	lung				
P.O. Box that the deeth cert ed by the ettendin detached for use:	Physician/I		d									
7 o he de ched	iysic	Part II. Other significant conditions of	ontributing to death	but not res	ulting in th	na underlying	g causa g	givan in Part I.	23b. <b>Di</b> d	l tobacco use co	ntribute to	tha causa of death
S, P.	by Ph								1	Yee 2 No	3 Prob	ably 4 Unknow
Records, e law requires these been signed be 2 should be a	Completed b								24a. Wa	s en eutopsy ormed?	ava	ra autopsy findings ilabla prior to apletion of ceusa eeth?
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ON/ Vital P vicien: The certificate	Be	25. Was casa rafarrad to medical axaminar?	Manager						ath (Chack only	ona)		
al this	10	1 ☐ Yas 2 ☐ No 27. Mannar of Daath	Hospital: 1 ☐ Inpat		ER/Outpa		DUA	thar: 4 Nursing I		idanca 6 DOth		)
After funer	tion	1 Naturel 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Tim Inju		28c. Inj W	uryat ork? ⊒Yas 2 □ No	280. Describe	how injury occur	red	
Vision Vision Attending r death. actor: Attention	Certification:	2 Accidant investigation 3 Suicida 6 Could not b		iune - At he	ome farm				28f. Location	(Streat and Numb	or or Purel	Pouts Number
Div.	ert	4 ☐ Homlcida datarmIned	building, a	tc. (Spacif	y)	, straat, ract	ory, office			wn, State)	or or rigrar	riodia rumber,
Divisio  To the Hospital or Attendi within 24 hours efter death To the Funeral Director: A	edicai C	Check only 2 Medical Exam	yeiclen: To the best niner: On the basis of	of examina	wledge, d	eath occurra	ad at tha	time, date and place	e, end due to the	a cause(s) and ma	anner es ste	etad.
thin 2 the	Med	Grie)	end manner s	tatad.								
5 × 5 0		29b. Signatura and titla of certifier	1 1	6	7	0	JU. LIGH	nse number	1)	29d. Date signe	U (MONTH, L	ay, rear)
.,4		2096	sh. A	- 1	all	ex	0	1877	U	8	1191	98
12		30. Nama and address of person who	completed cause of	deeth (Iten	n 23a) (Ty	pe, Print	IK	toa.	mn	21951	/	
	tate	31. Dete filad (Month, Day, Yaal)	32. Magist	rar's Signa	dure /		111	1000	MU C	11 101		
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

					0.0.0	man y nan		Certific	cate of	Death	.,	Reg. No.			
			1. Decedent's Name (First, I	Middla, La	st)						2. Date of De		W	3. Time of De	ath
	Physician		Jose	ph Fr	ench Abe	11					August	Day 12 1	Year 998	3:10 AM	ſ
٧.	/Medical	_	4a Facility Nama (If not inst							4b. City, Town, o	r Location of Death		-	0140	
	Examiner	١.													
1	5		St. Mary ' 5. Social Security Number	S HOS		Age (In yrs.	last birtl	nday) If L	Jndar 1 Yea			st.	Mary 9. Birtho	Solece (State or Fontry)	oreign
	Funeral Director		5 78 -1 2 - 15 28 Usual Residence of Decede	1	MM 2□F	4		rs. Mor	nths Days	Hours Mir		y, Yeer) 0, 1915		nington, I	
	pue *	-	10a. State 10b. Co			10c. Ci	ty, Town	or Location	n	_			1	I0d. Inside City L	imits
	fanylen f ehow	5	V 1 . 1 . 0 .											1 ☐ Yes 2 [	No No
	vith the Main or 28a-fe	3	Maryland St	. Ma	ry's		Lex		on Par	· K		10g. Citizen of	What Cour	ntrv?	
	Aith De C	5												ni y r	
	ath na 23	0	18080 Shippi	ng Po	12. Was Decede		1.0		20653	Historia Orlain?	Specify Vec or No	U.S.A	ce - Americ	ean Indian	
215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or frams 23s or 28s-f show not, the Mexical Examiner must be notified at a Completed by Funeral Director.	2	11. Marital Status  1 □ Never Married 2 ☑  3 □ Widowed 4 □ Dive		Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ☑ No	7,0.			ban, Maxican, Pua	(Specify Yes or No arto Rican, etc.)	Bla Specif	rck, White,		
0-10	2 ho	2	15. Dec	adent's E	ducation		16a.	Decedent's	Usual Occu	upation e during most of w	ndina	16b. Kind of E	lusiness/inc	dustry	
21	ges 1 and 2 should be filed within 72 ho t of Health and Mental Hygiene. If item 27 is marked other than "nature or other traumatic event, the Mexical To Be Commisted	2	Elementery/Secondary (0-	-	de completad) College (1-4	or 5+)		life. DO N	OT use retir	ed)	Urking				
21	d withi	5	12th	-		,	I	nstru	ment 1	laker		U.S. C	loveri	ment	
p	be file tal Hys d othe event,	0	17. Fathar's Nama (First, Mi	ddla, Last,	)						ame (First, Middle				
Maryland	2 should be filed within and Mental Hygiene. Is marked other than summit event, the Manatic event, the Manatic event, the Manatic event, the Manatic event, the Manatic events are summit to Revents and the Company of the Manatic events are summit to Revents and the Company of the Manatic events are summit to Revents and the Company of		George Leo	Abell						Unk	nown				
ary	shou man	•	19a. Informant's Name/Rela	tionship (	Type, Print)		19b.	Mailing Ad	dress (Stree		Rurel Route Numb	er, City or Town	, Stete, Zip	Code)	
	1 and 2: Health ar em 27 le		Donald Abel	1/Son			1	2404	Paler	no Drive	Silver	Spring	MD 1	20.00%	
altimore,	Health Item 27 other to	-	20a. Method of Disposition	27001		20b.	Place of	Disposition	(Name of	and DIIVE,	Silver	20c. Location	- City or To	own, State	
no	Peges net: if ite iry or of		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			ate					0/10/00				
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Ba	permit. Pege Dependent of Importent: If eny Injury or ance.		L / Constant of Fundament	1		-	0				ner Funer	al Home	, P.A	1.	
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в	B 1000		23a. Pert1. Inter the disease shock, or heart failure.	se, or com List only	plications that cau one cause on eac	sad the dea h line.	th. Øo n	ot anter the	mode of dy	/lng, such as cardi	ac or respiratory a	rrest,		Approximata Interval Between	
а	Physician	1				-								Onsat and Dea	ıtn
- 8	/Medical		Immediata Cause (Final disease or condition			(9)	101	ruc	- 6	irres	1		~/	12 18	
В	Examiner		resulting in death)		a.										
-	D = 5					10	ron	lar	1	ANTON	1:5	care	/		
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Box	atth cert attendin for use	2		-	d										
0	d for	2	Part II. Other significent co	nditione	ontributing to dont	h hut not ro	nultino In	the underly	dog onueo o	niven in Part I	23h Did	tobacco usa c	ontribute t	o the cause of c	dosth?
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	that det b		K	'sht	pleare	101	427	, or			_ ' ' '	Yes 20 No	3   10	bably 4 Dil	KIIOWII
Records,	requires that the death cereen signed by the attendin hould be deteched for use	2	/								24a Was	an autopsy	24b. W	/era eutopsy find	tings
0	The law require sets has been so page 2 should Completed										perf	ormed?	av	vailable prior to emplation of cau:	
ec	S 20 0												of	death?	
	The page	5									1 🗆	Yas 20 No	1[	☐ Yes 2☐ No	5
of Vital	ysician: The list certificate he director, page		25. Was case referred to me examiner?	edical						26. Place of D	eath (Check only	one)			
>	hysic alis ce il dire.		1 Yes 2 No		Hospital:	atient 2	ER/Out	patient 3	DOA C	ther: 4 Nursing	Home 5 ☐ Ras	dance 6 🗆 Ot	her (Specil	fy)	
0	g Ph er th		27. Menner of Deeth		28a. Date of I (Month,	Injury	28b. T	ime of	28c. Inj	ury at	28d. Describe	how Injury occu	irred		
Division	ath. r: Aff			ending vestigatio		Day 1001,	. "	N		Tyes 2□No					
Vis	Atte or de by th			ould not be etermined	286. Placa of	Injury - At h	ome, far	m, street, fa	actory, office	9		Street end Num wn, Stete)	ber or Run	al Route Numbe	r,
Ö	is after death.  el Director: After t led in by the funers  Certification:	5	4   Hornicide		bunding	, etc. (Speci	19)				Ony or 70	Wii, Dioloj			
	splta nours nere / fille	6	29a. Certifier 1 ☐ Cer	tifying Ph	ysician: To the be	est of my kn	owledge,	death occu	urred at the	time, date and pla	ca, end due to the	cause(s) and n	nanner as s	stated.	
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifiod completely filled in by the funeral director, Medical Certification: To Be C	2	(Check only 2 Med one)	dical Exar	niner: On the basi and manner		ation and	Vor Investig	ation, in my	opinion, death oc	curred at the time,	date and place	, and due to	o the cause(s)	
	withir outh	2	29b. Signature and title of co	ertifiar						nse number		29d. Date sign	ed (Month,	Day, Year)	
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**DHMH 16 Rev 6/9**5

JOSEPH FRENCH ABELL

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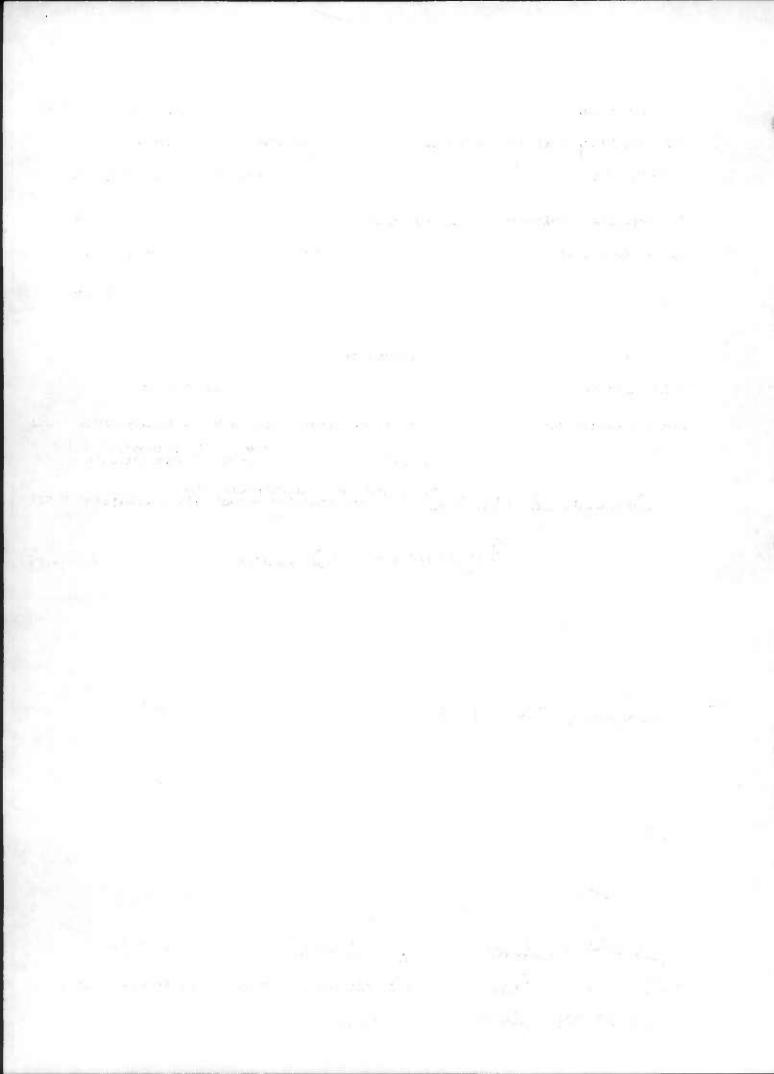
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DHMH 16 Rav 6/95



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 26979 State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (Fin	rst, Middle, Las	1)			rtificate of		2. Date of Dea	Reg. No. ath		3. Time of Death
Physi		Joseph Fr	ancis	Burke,	Jr.				AUGU!	STDay 3	1998	9:47 PM
/Med Exam		4a. Facility Name (If not						4b. City, Town, or Le			of Death	
.0:		Doctor's Co	mmunity	y Hospi	tal			Lanham		Princ	e Geor	rge's
Funera	1	5. Social Security Number			7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h v Vearl	9. Birthpia	ace (State or Foreign
Directo	r.	212-40-3390	4	M 20F	55	Yrs.	World Days	Tiours Will.	June 17	, 1943	Washi	ngton,D.C.
w g .		Usuel Residence of Deci	edent . County		10c C	ity, Town or Lo	cation				40	
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re ta		1 Never Married	2⊠ Married	Armed Fo 1 ☐ Yes	rces? 2X No			Hispenic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Bla	ck, White, e	
W 00 - 19	by	3 ☐ Widowed 4 ☐ [	Divorced	If Yes, Giv Year or D			1□ Yes 2XXVo	Specify:		Specif	whit	:e
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Maryla Maryla d 2 should th and Mar 7 is marks traumatic		19a. Informant's Name/F						Road, Hyai				
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Or A affar in by	Certification:	4 Homiclde	determined	buildir	ng, etc. (Speci	fy)	eet, factory, office		City or Tow	n, State)	oer or Hurar.	House Number,
Division of Vital Re To the Hospital or Attanding Physician: The la within 24 hours aftar death.  To the Funeral Director: Aftar this centificate ha completely filled in by the funeral director, page		29a. Certifier	CertifyIng Phy	sician: To the	hest of my kno	nwledne death	occurred at the ti	me, date and place,	and due to the	course(s) and m	annor oc eta	tod
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114		30. Name and address of	person who o	ompleted cause	e of death (Iter	m 23e) (Type	D :			1	-	10
(1)		John	B 7	170	BAU	D5 A	10 9	811 Ma	llard	010	Laure	LM.D.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death

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ı	Funeral		5. Social Security Number	6. Sex 1X M 2□	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Yes		r 24 Hrs.	8. Date of Bird (Month, Da	ih y, Year)	9. Birthple Count	ace (State or Foreign
	Director			I	58					5-29-	40	Wash	D.C.
}	how		Jsuel Residence of Decedent  10a. State 10b. County	/	10c. C	tity, Town or Lo	cation					10	d. Inside City Limits
-	death with the Maryland ms 23s or 28s-f show firsts be notified at	Funeral Director	MD Princ	e Geor	ge's F	orrest	iville				10g. Citizen of	What Count	XXYes 2 No
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bug		Be	7. Father's Name (First, Middle								Maiden Sumar	me)	
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00	death e atter		Pert II. Other significent conditi	ons contributing	to death but nof re	sulting in the ur	nderlying cause	given In Part	i.	23b. Did	tobacco ues co	ontribute to	the cause of death?
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	To the Hospital or Attending Physician: The law requires thet the death within 24 hours effer death.  To the Funeral Director: After this centificate has been signed by the atter completaly filled in by the funeral director, paga 2 should be detached for the funeral director, paga 2 should be detached for the funeral director.	_	29a. Certifier (Check only one)	Examiner: On the	the best of my kn ne basis of examin manner stated.	nowledge, death	occurred at the restigation, in m	time, date a y opinion, de	nd place, a	and due to the ed at the time,	cause(s) and m	anner as st	ated. the cause(s)
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	(3)	3	10. Name and address of person	who completed	cause of death (Ite	om 23a) (Type, I	Print) D	rive	G	lan 1	Surner	e m	5. 24061.
			11 Date filed (Month Day	1	20 Pomietra da Ci	natura							

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Kenneth Anthony Brown Aug.12,1998 05:30pm /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 120 M 2□ F 578-78-7364 40 Yrs. Director August 3, 1958 Washington, D.C. Usual Residence of Decedent with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23s or 28s-f show Examiner must be notified at 1 X Yes 2 □ No Director Prince George's Maryland Landover 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1905 Belle Haven Drive, #303 20785 U.S.A. deeth Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forcas? 1 (X)Yes 2 □ No 11/79 If Yes, Give 9/83 Yaer or Detes: 9/83 Wes Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example page. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Black 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Custodian Government 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pierce Benjamin Mary Helen Deale 19e. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) Karen V. Thornton/Ex-wife 10017 Cedar Hollow Lane, Upper Marlboro, MD 20772 20b. Piece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 08/18 1 XBurial 2 Cremetion 3 Removal from State Maryland Veterans Cemetery 1998 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signeture of Funarai Service Licensee J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the diskuse, or complications that caused the deeth. Do not antar tha mode of dying, such es cardiec or respiratory arrest, shock, or heer failur. List only one ceuse on each line. Approximete Intervel Between Onset end Death **Physiclan** /Medical Immediate Causa (Final CRYPTOCOCCAL MENINGITIS disaese or condition rasulting In death) Examiner Due to (or es e consequanca oi) Examiner requires that the death certificate be executed attending physician end for use as the burial-translt Sequentielly list conditions, if any, leading to immadiate ceusa. Entar Underlying Cause (Diseese or Injury that initiated events rasulting in deeth) Lest Due to (or es e consequance of): Box 68760. Physician/Medical Dua to (or as e consequence of): P.O. 1 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by 1 □ Yas 2 No 3 Probably 4 Unknown MUMAN IMMUNODEFICIENCY VIRUS Records, þ Be Completed 24b. Were autopsy findings eveilable prior to 24a. Was an eutopsy performed? complation of cause of death? page 2 1 ☐ Yas 2 ☐ No certificate of Vital or Attending Physician: director, 25. Was cese referred to medical axaminer? 26. Pleca of Death (Check only ona) 1□ Yes 2 No Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural Accidant 5 Pending investigation n 24 hours after death.

Ne Funeral Director: Aft
pletely filled in by the fur 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be datermined 28e. Plece of Injury - At home, larm, street, lectory, office building, atc. (Specify) 28I. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Hospital Certifying Physician: To the bast of my knowledge, death occurred at tha time, date end plece, end due to the ceusa(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, daath occurred et the time, date end plece, end dua to the causa(s) end mannar stated. Medical 29e. Certifier To the Hosp within 24 hou To the Fune completely fil (Check only title of cert 29b. Signature 29c. License number 29d. Date signed (Month, Dey, Yeer) 52563 Aug. 13, 1998 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Typa, Print) Pawan Arora Md 1500 Forest Glen Rd. Silver Spring Md 20901 31. Dete filed (Month, Day, Year) 32 Registrer's Signature State AUG 1 8 1998 Registrar

**DHMH 16 Ray 6/95** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Barbara Jean Barrett August 15, 1998 8:25A.M. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1943 Portsmouth, 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10M 20F 227-56-4897 55 Director Usuel Residence of Decedent 10b. County 10c City Town or Location "natural", or items 23s or 28s-f show idlest Examiner must be notified at 10d. Inside City Limits 1□ Yes 2□ No Directo Maryland | Prince George's Forestville 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 7420 Marlboro Pike 20747 USA 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 ☐ No Specify Black à 3 ☐ Widowed 4 ☑ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ith and Mentel Hygiene. 27 ie marked other than "r r treumatic event, me Med flied within Elementary/Secondary (0-12) College (1-4or 5+) File Clerk Government Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hant: If item 27 is marked oth jury or other treumstic even 8 Unknown Paige Taylor 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5225 Marlboro Pike #203 Capitol Hgts., MD. 20743 Kimberly Barrett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 18/18/98 Alexandria, VA. Metropolitan Crematory 22. Name and Address of Facility turn of Juneral Service License Alexander S. Pope Funeral Home 5538 Marlboro Pike Forestville, Maryland 20747 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only sine cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in death) Examiner Examiner Min ara The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760. Physiclan/Medical Due to (or as e consequence of): for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? ,1□ Yes 1 ☐ Yes 2 ☐ No cartificate Division of Vital 25. Wes case referred to medical examiner? Attending Physician: funeral director. 26. Place of Deeth (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Donatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Deat 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 Naturat 5 Pending deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deet Funeral Director: 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 6 filled in Hospital 11. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12825012

State Registrar

AUG 1 9 1998

Date filed (Month, Day, Year)

32. Registrer's Signeture

FIRE I BIGGS . See-me . J. Sept B I DUG

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 26983

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Physician /Medical		atheria		Beverly						AUGUST	17, 1	998	5:29 P.M
Examiner	4a Facility Name (If not in	stitution, give	street end nun	nber)			4	b. City, To	wn, or Lo	cation of Dear	th 4c. Cou	nty of Deat	h
	MALCOLM GRO		CAL CEN	TER				CAMP					ORGE'S
Funeral	5. Social Security Number	1[	M 2 AF	7. Aga (In yrs. le:	st birthday) Yrs.	if Under Months	1 Year Deys	If Undar Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ey, Year)	9. Birt	hplace (Stete or Foraig untry)
Director	127-14-3343 Usual Residence of Deced			78	170.					Nov. 2	28, 191	9 Pen	nsylvania
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28a-f show notified at rector	Maryland Pr	rince (	George!	Ov	on Hi	11							1 Yes 2 N
28a-f	10e. Street and Number	Thee	deorge s	5 OA	011 111	10f. Zip	Code				10g. Citizen	of What Co	untry?
r fems 23s or 28s-1 s ciner mant be notified Funeral Director	5916 Terre	ell Ave	enue			2	2074	5		W 54	U.S	. A.	
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Fur	1 Never Marriad 2	Married	Armed For	2 X No						Rican, atc.)		Bleck, White	
by	3 ☐ Widowed 4 ☐ Di	ivorced	If Yes, Give Year or Da	tes:		1□ Yes	2 JU No	Specify:			Spe	Whi	te
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2	Frank Sin	mons								Petro			
	19e. Informant's Name/Re										ber, City or To		Zip Code)
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or other tr	20a. Method of Disposition		Ramoval from S	toto Cer	netery, crei	netory or o	ther pled			Date	20c. Location		
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4	21. Signature of Funeral S	iervice Lipens	19 1	1		2. Name an				1 T	T D	Α .	
8	" Heara	111	ales 1	4							Home, P		45
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ai	Immediate Cause (Final disease or condition		INTRA	CRANIAL	HEMO	RRHAG	E					†	4 DAYS
er	resulting in death)		a	Due to (or									7 21110
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Medical Examiner	that initiated events resulting in death) Last			Due to (or a	s a conseq	(uence of):						i	
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Be Completed by	25. Was case referred to examiner?		140411		R/Outpetier 8b. Time o	nt 3 DC	JA	4 LI NI	ursing Ho		how injury oc		cify)
Jo-	examiner? 1 Yes 2 No		(Monti	i Injury n, Dey Year)	Injury	M	28c. Injur Wor	k? Yes 2□	No	200. Describe	, now injury oc	out 100	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 70 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 8:00 P.M. DEWITT BUTLER August 16,1998 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 4714 MANN STREET Capitol Hgts. Prince George's If Under 1 Months 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Days 1X M 2□ F 243-07-7398 81 Dublin, Ga. Usual Residence of Decadent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. P.G. Capitol Hgts. 1 ☐ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4714 Mann St 20743 14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 XYes 2 No
If Yes, Give 1 42 - 143 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 X Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Security Guard D.C. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Butler Gertrude Wilcher 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sallie M. Anderson/Sister Same as # 10 above 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 8/20/98 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State Quantico Nat'l. Cem. Triangle, Va. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee

22. Name end Address of Facility
H. S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N. E., Wash., D. C.

23a. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest.

Approximate Approximate Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en europsy performed? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer?

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10e. State

**Funeral** 

**Director** 

a or 28a-f show

Examiner meet t

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Pages 1 end 2 should be nent of Haaith and Mental

nt of Haaith a if item 27 is

permit. Pages 1 Department of H Important: If ite any injury or ot once.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of Vital Records.

Attending Physician:

Director

Funeral

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Be Completed

2

The law requires that the death certificate be executed pue buriel-tran the as à 8 pege 2 should certificata has director. this funeral After daath.

à Be 2

Completed

effer daath Director: A ne Hospital or Attendant 24 hours efter dans Puneral Directo To the Hosp within 24 hou To the Fune complately fi

Medical

State Registrar

Physician/Medical Examiner Certification:

29b. Signature and lifte of cortified

5 Pending Investigation

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and menner stated.

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospitel: 1 ☐ Inpatienf 2 ☐ ER/Outpetienf 3 ☐ DOA

28b. Time of

29c. License number

20182

28c. Injury et Work?

1 Yes 2 No

29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Plece of Deeth (Check only one)

Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

28d. Describe how Injury occurred

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Leslie W. Kingslow, M.D. 1160 Varnum St., N.E. # 214, Wash., D.C. 20017

31. Defe filed (Month, Day, Year) AUG 2 0 1998

1 ☐ Yes 2 No

27. Menner of Deeth

1 Naturel

2 Accident 3 Sulcide

4 - Homicide

29a, Certifier

32 Registrer's Signeture

DHMH 16 Rev 6/95

WRC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician EDITH MAGNESS** BULL AUGUST 20, 1998 10:25 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Days 1□ M 21 F Yrs 90 Director November 20, 1907 Mary land 212-74-7177 Usual Rasidance of Dacedent with the Maryland 10a State r than "natural", or items 23s or 28s-f show the Maoical Examiner must be notified at 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yas 2 No Directo MARYLAND PRINCE GEORGE'S BRANDYWINE 10a. Street and Number 10f. Zip Coda 10g, Citizan of What Country? 12511 BRANDYWINE ROAD 20613 U.S.A. death 1 Funeral 12. Was Decedant Evar In U.S. Armad Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: if Item 27 Is marked other then "natural", or iter any injury or other traumatic event, the Mexical Exertine any injury or other traumatic event, the Mexical Exertine Dines. 1 ☐ Yas 2 🕅 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: WHITE þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Surneme) Be CLARENCE TILTON MAGNESS MAGGIE CARMAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Coda) JAMES M. BULL, JR./SON 12511 BRANDYWINE RD, BRANDYWINE, MARYLAND 20613 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of D 20c. Location - City or Town, Stata 1 X Burial Cramation 3 Ramoval from State DEER CREEK CEMETERY 08-24-1998 CHESTNUT HILL, MD har (Specify) THE HUNTT FUNERAL HOME, INC. BROHAWN M00053 MARK G. P.O. BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final Povernow A 2 days disaasa or condition resulting In daath) Examiner Dua to (or as a consequence of) CARRIOVASUNAY DISEASE Examiner physician and s the burial-transit Saquantially list conditions, if any, laading to Immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of) 88 ed by the attanding datached for use as Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably Wunknown Records. p should t 24b. Wara autopsy findings availabla prior to completion of causa of daath? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was cesa rafarred to madical 26. Placa of Daath (Check only ona) Hospital: 2 1 Yas XXNo 1 XInpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) this funeral 28a. Deta of Injury (Month, Day Yaar) 27. Mennar of Daath 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Attanding After Natural 5 Panding invastigetion daath. 1 Yes 2 No To the Hospital or Attandi within 24 hours aftar death. To the Funeral Director: A completely filled in by the fi 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 - Homicide 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and menner es steted.

2 Medicel Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred et the time, data end place, and dua to tha ceuse(s) and mannar statad. edical 29a, Certifier 29b. Şignature and title of certifiar 29c. Licansa number 29d. Data signed (Month. Dav. Year) 001923 Treldo AUGUST 21, 1998 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) THOMAS L. FIELDSON, MD, 2068 CRAIN HWY., WALDORF, MARYLAND 20601

DHMH 16 Rev 6/95

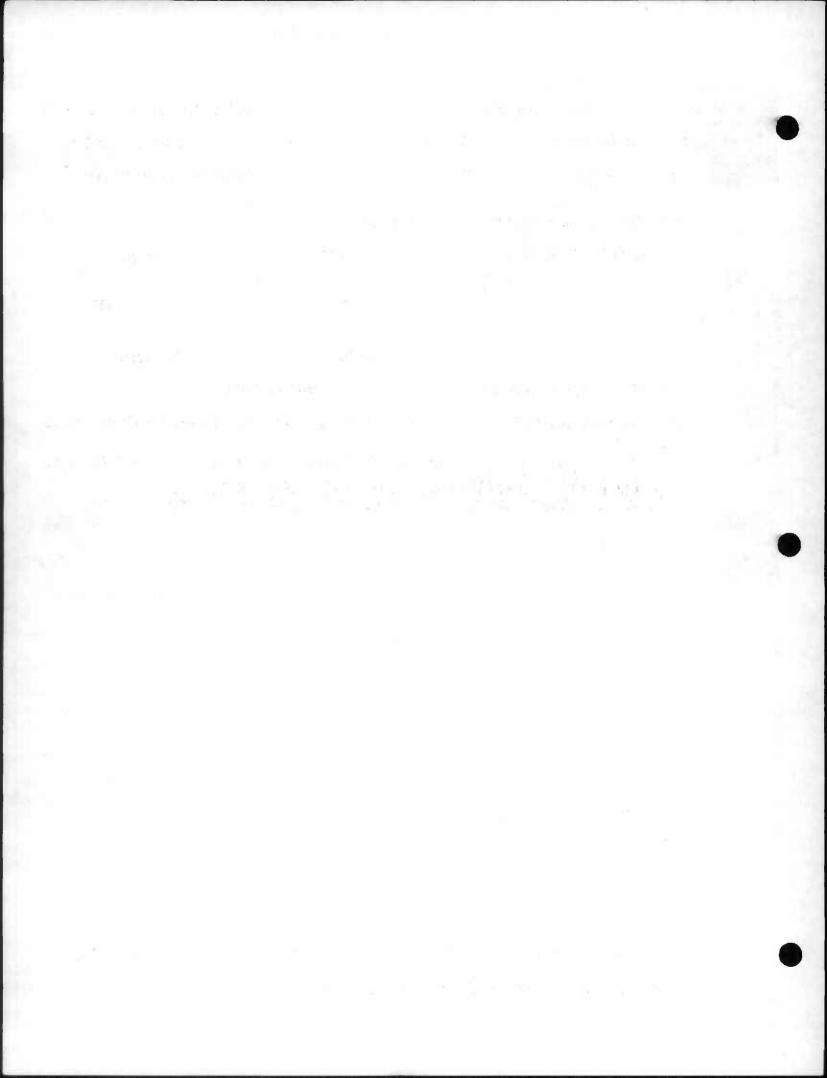
State

Registrar

31. Data filed (Month, Day, Year)

AUG 25

32. Ragistrar's Signatura



**Funeral** Director JAMES BARNES Baltimore, Maryland 21215-0020 permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinat must be notified at once.

**Physicia** /Medic Examin

**Physician** /Medical **Examiner** 

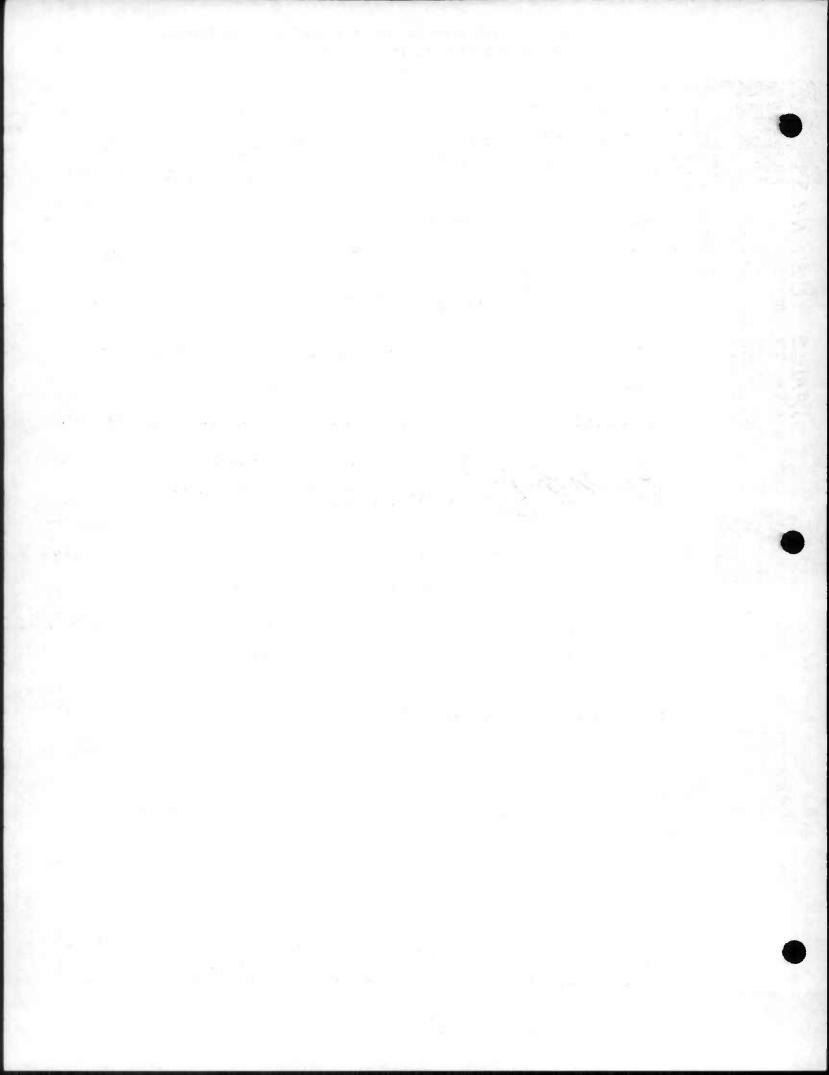
To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 42 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deleched for use as the burial-trensit ate hes been signed by the attending physician end page 2 should be deteched for use es the buriel-trensit Division of Vital Records, P.O. Box 68760,

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	ation 5 Other (	Specify)	1 90		Claver		8-15-98	St. Ini	goes, Maryla
21. Signatus	1612/11	125m/W	1/		Name end Add	rass of Facility  Ld Funera	1 Home	DΛ	
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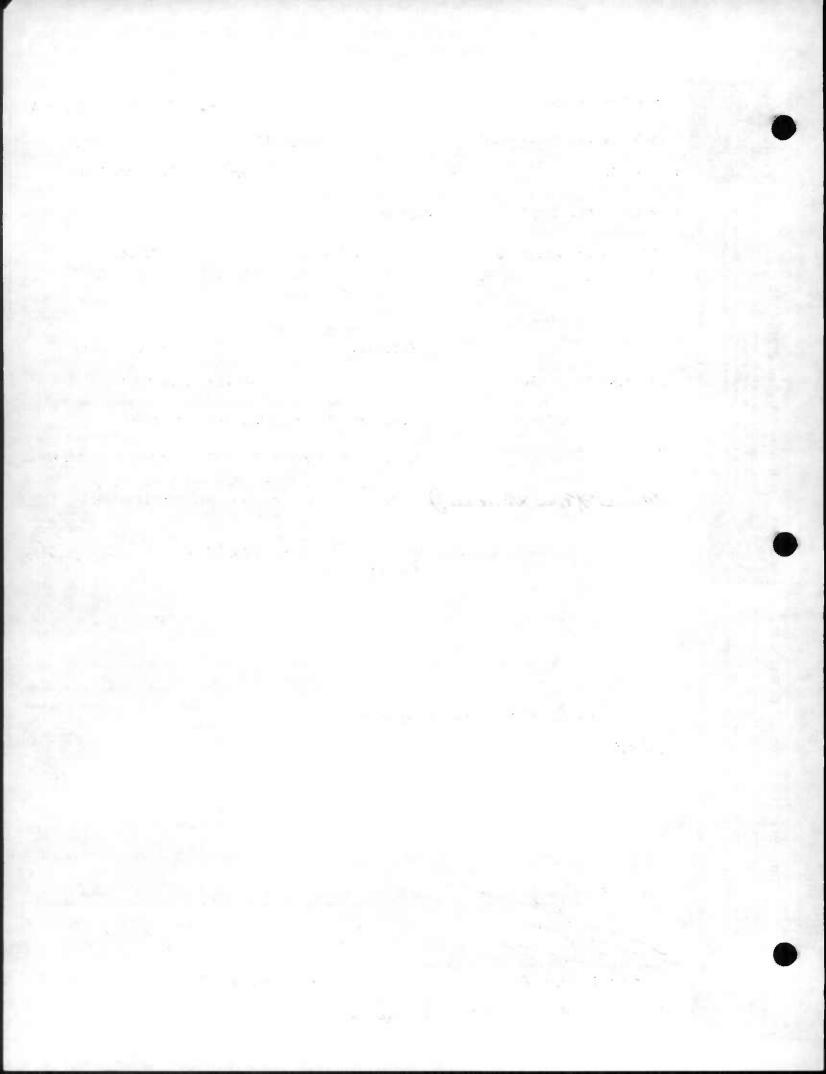
DHMH 16 Rev 6/95 7+18

Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible

	Certificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)  James Harry Bailey	2. Dete of Deeth Month Dey Yeer August 19, 1998 10:13 AM
/Medical Examiner Funeral Director	26055 Laurel Grove Road  5. Social Security Number 577-09-9132  6. Sex 1 Morganz 7. Age (In yrs. lest birthday) 87 Yrs.  Months Deys Hours M	or Location of Deeth 4c. County of Deeth St. Mary's
show	Usuel Residence of Decedent  10a. Stete 10b. County 10c. City, Town or Location  Maryland St. Mary's Morganza	10d. Inside City Limits 1 ☐ Yes 2X No
or 28a-fs. be notified	10e. Street end Number 10f. Zip Code	10g. Citizen of Whet Country?
at, or items 23a or 28a-f show Examiner must be notified at by Funeral Director	26055 Laurel Grove Road  11. Maritel Status  1 Never Married  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Married  1 Never Married  2 Married  1 Never Married  2 Married  1 Never Married  2 No Specify:  1 Yes, Sive  1 Yes, Specify Cuban, Mexican, Pu  1 Yes 2 No Specify:	U.S.A.  (Specify Yes or No- erro Rican, etc.)  14. Raca - American Indien, Bleck, White, etc.  Specify: White
natur edical	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12) 8th  16e. Decedent's Usual Occupation (Give kind of work done during most of ville. DO NOT use retired) Salesman	working  16b. Kind of Business/Industry  Milk Company
i and Mental Hygiene. Is marked other than summitic event, tra.M. To Be Comp	17. Father's Neme (First, Middle, Last)  John Franklin Bailey  18. Mother's P	Name (First, Middle, Meiden Sumeme) Alberta Marie Long
uith end Mental 27 is marked o r traumatic ever		Rurel Route Number, City or Town, State, Zip Code)
Department of Health important: If item 27 is any injury or other tronce.	20a. Method of Disposition  1 Burial 2 Cremetion 3 Removal from Stete  4 Donetion 5 Other (Specify)  20b. Place of Disposition (Name of cametery, crematory or other place)  Charles Memorial Gardens	Dete 20c. Location - City or Town, Stete
ettending physician end bronding physician end bronding bronding to the burial-transit clary. Clary Medical Examiner	Cause (Disease or Injury that initiated events resulting in deeth) Lest  Due to (or as a consequence of):	Heart Failure on this
signed by the ettending d be deteched for use e	Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I.  Peryheral Varcular Jersen	23b. Did tobecco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
s been s 2 should pieted		24a. Wes en eutopsy performed?  24b. Were eutopsy findings eveileble prior to completion of cause of death?
certificate ha		1 ☐ Yes 2 No 1 ☐ Yes 2 No
effer death.  Director: After this I in by the funerel di  ertification: To	examiner? 1   Yes 2 No	g Home Star Residence 6 Other (Specify)  28d. Describe how injury occurred  28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
within 24 hours  To the Funeral  completely filled  Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place (Check only one)  2 Medicaf Exami on the basis of examination end/or investigetion, in my opinion, deeth or and menner steted.	ccurred et the time, date end plece, end due to the ceuse(s)
C T Wil	29b. Signature and ISB of Cartifler  29c. License number  5/99/7	29d. Date signed (Month/Day, Year)
de la	James C. Boyd, MD California, Ma	ryland 20619
State Registrar	AUG 2 4 1998 Server 9. Asouls	



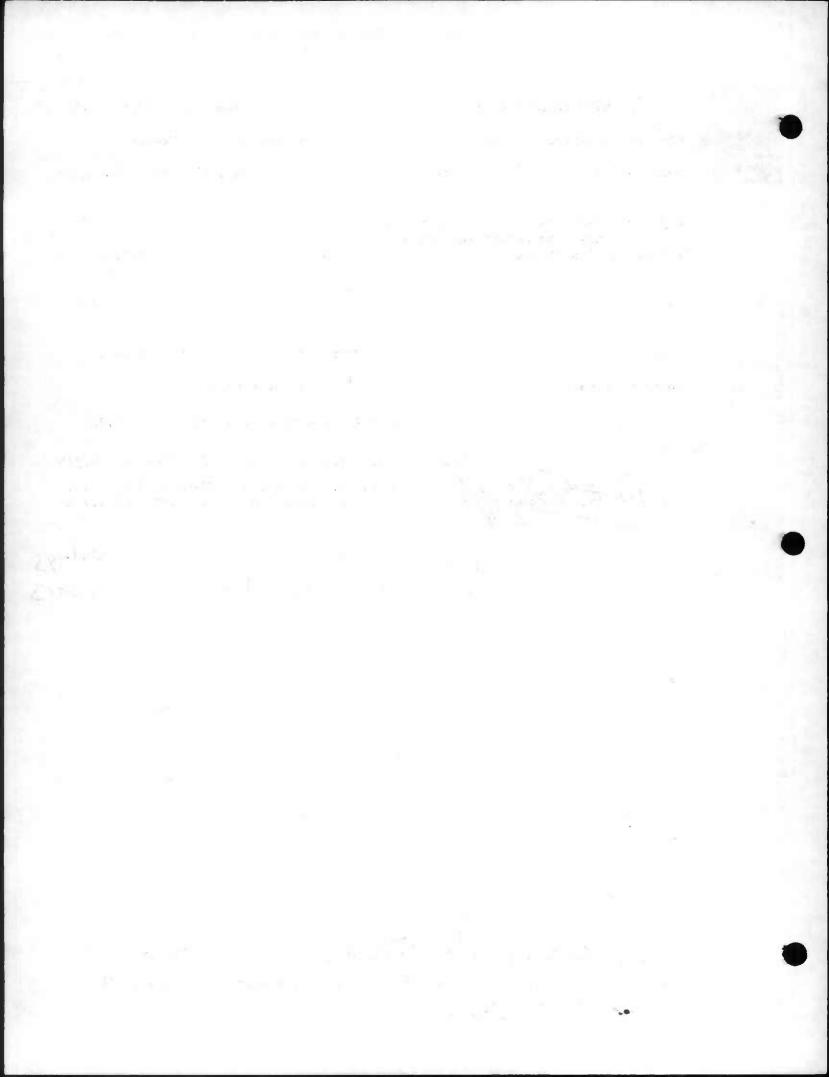
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be or Print in Black Indelible ink. Assure All Co tate of Maryland / Department of Health and Ment	tal Hygiene 🗸 🔾	60	9	ď .	J
Certificate of Death	Reg. No.				

	Physici /Medic	_	1. Decedent's Name (	First, Middle, La		HEN						1	2. Dete of De Month August	Dey	Yeer 998	3. Time 4:45	of Deeth
	Examin		4e. Fecility Neme (If n										ocation of Dee				
	Funeral Director		Homewood  5. Social Security Nun 392-14-37	nber 6. S			'In yrs. lest b	oirthday) Yrs.	If Under Months	1 Yeer Deys	If Unde	eder Min.		fred (17, 1921)	9. Birthp Cour Wis		or Foreign
	show		Usuel Residence of D 10e. State 1	ecedent 0b. County		1	Oc. City, To	wn or Loc	cation							0d. Inside	
	death with the Marylend  ms 23a or 28a-f show  mass be not red at	Funeral Director	Maryland 10e. Street end Numb	Frederi erHomewo		reme	Fredont Cer			Code				10g. Citizen of	Whet Cour		s 2 No
	23a c	raic	31 West Pa	trick S	treet					217	01				U.S.A	i.e	
	or its	by	11. Merital Status  1 Never Merried  3 Widowed 4		12. Wes Dec Armed Fo 1 Tes If Yes, Gi Year or D	20 No	er in U,S.	If	Yes, spec	cify Cut	Hispenic O pen, Mexica Specify	in, Puerto	ecify Yes or N Rican, etc.)		ck, White,	en indien, etc. hite	
5-0	"neturel",	eted		5. Decedent's Ed			16	e. Deced	ent's Usue	el Occu	pation	st of work	ina	16b. Kind of B	usiness/In	dustry	
121	than	Completed	Elementary/Second		College (	1-4or 5+)			ane C		during mo	or or work	"19	Ladis	h Inc		
70	4 4 4 E	Be	17. Fether's Neme (Fit					OI.		per	18. Moth		e <i>(First, Middle</i> Schultz	, Maiden Sumer		•	
ary	end Mental end Mental is marked or sumatic eve	L <sub>o</sub>	19a. Informent's Nam				19	b. Mailin	g Address	(Stree	t end Numi	ber or Run	el Route Numb	per, City or Town,	Stete, Zip	Code)	
- 1	Health er Health er am 27 is other trau		Jean R. Bu	chen (S	on)		34	41 W	est F	atr	ick S	tree	t, Fred	lerick,	MD 21	701	
Baltimore	Department of He moortant: If Itam way injury or other and		20a. Method of Dispos 1 Burial 2 0 4 Donetion 5	Cremation 3 [		State	20b. Plece cemet	e <i>ry</i> , c <i>r</i> em	etory or o	ther ple		1	Dete 8/24/98	20c. Location Freder			and
Balti	Depertment Important: I eny injury o		21. Signature of Figure	Service Lies	200	A	5	22. R0	Name en OBERT	d Addr	ess of Feci DAIL	EY &	SON FU	JNERAL H	OMES,	P.A.	
	Physician Medical Physician and Medical Physician and Medical Physician and Physician	fical Examiner	Immediate Ceuse (Fir disease or condition resulting in death)  Sequentielly list condition, leading to immeause. Einter Underly Ceuse (Disease or injubet initialed events resulting in death) Les	itions, ediate ing ury	e b	Du	ue to (or as e	Consequ	uence of):		14	112	tus			ye	115
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, P.O. Bo	ed by th	y Physici	Pert II. Other significa	nt conditions o	ontributing to d	eath but n	not resulting	in the un	derlying c	ause g	iven in Perl	1.		Yes 2540			of death?
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ital		Be C	25. Wes case referred exeminer?	I to medical							26. Pled	e of Deet	h (Check only	one)			
vision of Vita	fter th Ineral	2	1 Yes 2 No. 27. Menner of Deeth	5 Pending investigation	28e. Dete (Mon	Inpatient of Injury th, Dey Y		Outpetient Time of Injury		8c. inju				idence 6 Oth		V)	
Divis	efter des Director d in by th	Certification:		6 Could not be determined	286. Place	of Injury ing, etc. (	- At home, (Specify)	farm, stre	et, fectory	, office	8		28f. Location City or To	(Street end Numl own, Stete)	per or Rura	Il Route Nu	m <i>ber</i> ,
To the Classification	within 24 hours efter death.  To the Funerei Director: After thi completely filled in by the funeral	edicai C	29a. Certifier (Check only one)	Certifying Ph	iner: On the ba	best of masis of ex	ceminetion a	je, death nd/or inve	occurred estigetion,	at the t	ime, dete e opinion, de	nd plece, ath occur	end due to the red et the time	cause(s) end m , date end place,	enner es s end due to	leted. the ceuse	(s)
	withir To th comp	Me	29b. Signature and lift 30. Name and andress	and certifier	Completed cause	C C	lu (Itam 230	9 11	DI	2 Licen	se number	645	28	29d. Date signe August			
			Casper E.							tre	et, F	rede	rick, M	aryland	2170	1	

State Registrar

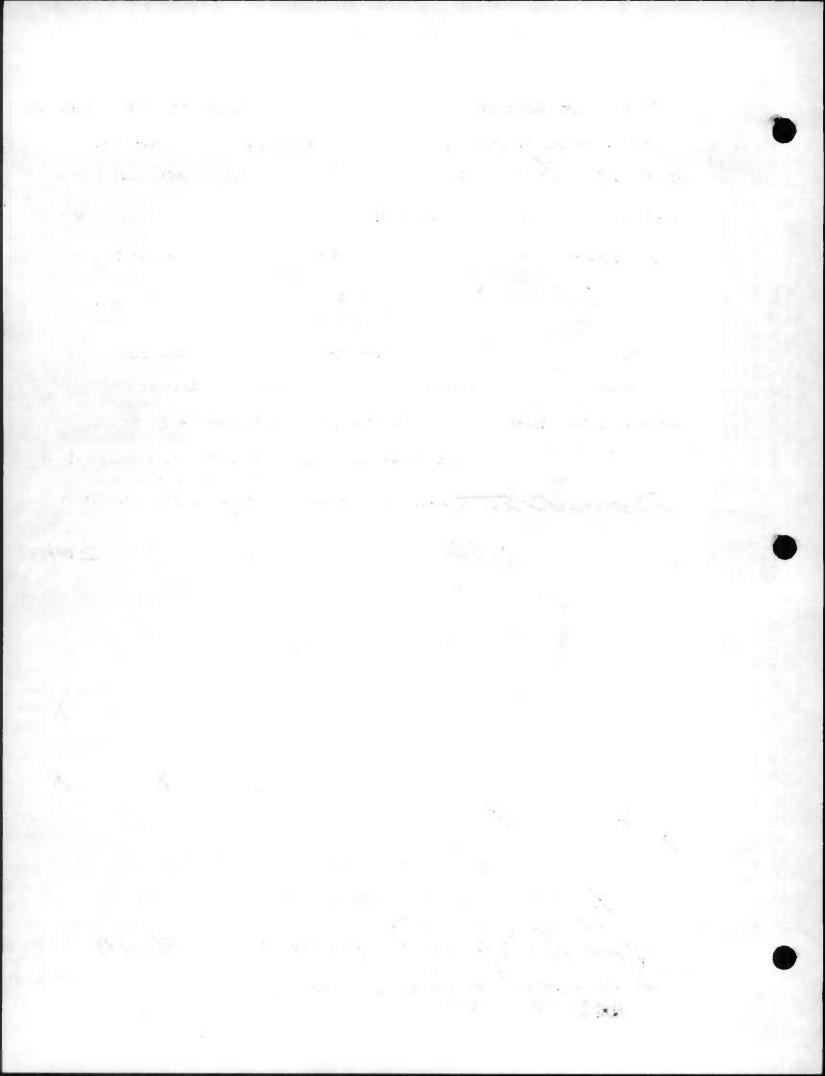
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				Ce	rtificate of	Death		Reg. No.		A 77 17.
	(First, Middle		. 1.				2. Dete of I Month	Dey	Yeer	3. Tima of Death
Ralph a Fecility Neme (If	_	nd Behre				4b City Town	Augus 7			5:25 P.M.
N 31 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				-1		Frede			derick	
. Social Security Nu		morial F	7. Age (/	a 1 In yrs. last birthdey)	If Undar 1 Yeer Months Days	If Under 24	Hrs. 8 Data of E			ce (Stete or Foreign
472-10-91	111111111111111111111111111111111111111	M 201	8	4 Yrs.	Months Days	Hours		21,1913	Minne	
Jsuel Residence of I	10b. County		10	Oc. City, Town or Lo	ocation				10	d. tnside City Limits
Virginia				Alexan						1 Yes 2 □ No
0e. Street end Num	nber				10f. Zip Code			10g. Citizen of	Whet Countr	y?
6408 V	ale St				2231	2		Unite	d Stat	.00
1. Marital Status	are bt	12. Was D	ecedant Eve Forcas?	er in U,S. 13.			n? (Specify Yes or it Puerto Rican, etc.)	1	ce - Amarica	n Indien,
1 Never Merrie		ed 1 Yes,	es 2 No		1 ☐ Yes 2 No		Puerto Hicari, etc.)	Specia	ick, White, e fy: Whit	
/Consider	15. Decedent	's Education		16e. Dece	dent's Usuel Occu	petion	d working	16b. Kind of E		
Elementery/Secon	, , ,	t grede complete Colleg	e (1-4or 5+)		kind of work done DO NOT use retire		working			
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7. Fether's Neme (F		_ast)	Ro	hrendt		1	s Neme <i>(First, Midd</i> nn	Mollner		
F F all		in (Type Print)	ье		na Address /Stree		or Rurel Route Num			Code)
Marianne			er				s Ct./ Mt			
Oa. Method of Dispo	osition			20h Place of Dispo	osition (Neme of		Date	20c. Location		
1 Durial 2 4 Donetion			om State	cemetery, cre Hagerstow	m <i>atory or other ple</i> on Cremat		8-24-98	Hagerst	own . Ma	rvland
21. Signature of Fun					2. Nama and Addr		Stauffer			-1 ) 20110
Dans		10	1		E Rida	eville	Blvd./ M			1771
23a. Part1. Enter the	a disaasa, or	complications th	at causad the							Approximate Intervel Between
snock or near	t tallure. List o	only one cause of	on eech line.							Onset end Death
Immediete Ceuse (F diseese or condition	Final	. (	·VK	7-						2WKs
resulting in deeth)		Ø	Du	e to (or es e conse	quence of):	_				
		b								
Sequentially list con- if eny, leading to imr	ditions, mediate		Du	e to (or es e conse	quenca of):					
Sequentially list confidency, leading to immodule to immodule to immodule to the confidence of the con	lying njury	c								
resulting in death) Lo	est		Due	e to (or as e consec	quence of):					
		d							1	
	cant condition	ns contributing to	o death but n	not resulting in tha L	indarlying causa di	iven in Part I.	23b. Di	id tobacco use c	ontribute to	the cause of death?
Part II. Other signific							11	□Yes 2□No	3 Prob	ably 4 Unknown
Part II. Other signific										/'
Part II. Other signific										e eutopsy findings leble prior to
Part II. Other signific				E2 :				as an autopsy rformed?		pletion of cause
art II. Other signific									com	eeth?
Part II. Other signific							pe		of d	
Part II. Other signific	ed to medical	Alexander			1-		pe	rformed?	of d	eeth?
25. Was case referre examiner? 1 □ Yes 2	No.		Inpatient	2□ ER/Outpetie	III SLI DOA	ther: 4 Nurs	pe 1[ of Deeth <i>(Check</i> on) sing Home 5 ☐ Re	Yes 2 No	1 □	eeth? Yes 2 No
25. Was case referre examiner? 1 Yes 2 Y	¶o 5 ☐ Pending	28e. 5	Inpatient ete of Injury Jonth, Dey Y		of 28c. tnju	ther: 4 Nurs	of Deeth (Check only sing Home 5 🗆 Re 28d. Describ	Yes 2 No	1 □	eeth? Yes 2 No
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25. Was case referre examiner? 1 U Yes 2 1 27. Namer of Seeth 1 Neturel 2 Accident	5 Pending	28e. E	ete of Injury fonth, Dey Y	28b. Time of Injury	of 28c. tnju	ther: 4 Nursury et ork?	ing Home 5 Re 28d. Describ	Yes 2 No y one) sidenca 6 One how injury occu	ther (Specify,	eeth? Yes 2 No
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Amend: #5 Per FH Film G763 9-11-98RC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Year 8:15 AM BOWSER August 13, 1998 EDWARD /Medical 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 7603 Mathis Lane Mt. Airv If Under 24 Hrs. Hours Min. 5. Social Security Number 216-40-3320 216-40-3820 If Under 1 Year 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dev. Yeer) Birthplace (Stete or Foreign Country) **Funeral** Months Deys 1 M 2 F Yrs Director Febr. 6, 1943 Pennsylvania Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "netural", or items 23a or 28a-f show Director 1 ☐ Yes 2 No Maryland Carroll Mt. Airy 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 7603 Mathis Lane 21771 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 270 No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 11. Marilel Sletus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) d 2 should be filed within 72 hours effer the end Mentel Hygiene.
7 is marked other than "netural", or itel traumatic avent, in the end in the 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☒ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Board of Education 12 Custodian 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Peges 1 and 2 should be finent of Health and Mentel I int: If Itam 27 is marked of Luther Bowser Mildred Miller 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Leslie Bartlebaugh /daughter itam 2. 304 Redwood Ave. / Frederick, Maryland 21701 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 Cremation 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or once. = 5 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 8-14-98 Hagerstown, Maryland 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike/ Frederick, Md. 21702 elerson monde 23a. Part. Effort the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onsel end Deeth **Physician** METASTATIC PROTATE CANCEL /Medical Immediete Ceuse (Final 7 YEARS disease or condition resulting in death) Examiner Due to (or as a consequence of). The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burie Box 68760. Physician/Medical Due to (or es a consequence of) as P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Records. þ page 2 should 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No certificate Vital or Attending Physician: director, 25. Was cese referred to medicel exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpetient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To of this funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division After Natural 2 Accident 5 Pending investigation efter death. 1 ☐ Yes 2 ☐ No 3 ☐ Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours e To the Funeral C completely filled to the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted. 29a. Certifier Medicai ş 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) FRESERICK MD 21761 SOI W. SEVENTH ST. CONNOR MA SPYAN M. 0 32. Registrer's Signature 31. Dete filed (Month, Dey, Year) State AUG 1 Registrar

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 98 26992

			Cer	titicate	e or i	Death		H	leg. No.			
1. Decedant's Nama (First, Middla, i	Last)							Data of Dea Month	th Day	Yaar	3. Tima of Death	
dical Rosemary	Marrow	Casl	er					igust		998	2:07PM	1
niner 4a Facility Nama (If not institution, g					- 4	4b. City, Tov			4c. County	of Death		
The Memorial	Hospital					East	on		Talb	ot		
		ga (In yrs. last I	birthday)	If Undar		If Undar 2		Data of Birth	Vaari	9. Birthple	oce (State or Forei	ign
113-07-3369 Usual Rasidance of Decedant	1□M 200 F	83	Yrs.	Months	Days	Hours		(Month, Day			land	
10a. State 10b. County		10c. City, To	wn or Lo	cation						10	d. inside City Limi	ts
MD Talbo  10e. Street and Number  30564 Skipton  11. Marital Status  1 Never Married 2 Married	t	Cord	ova	1 :							1 ☐ Yes 2 📉 N	10
10e. Street and Number				10f. Zip				1	log. Citizan of V		ry?	
30564 Skipton	-Cordova	Rd.		21	1625	5			U.S.			
3 ☑Widowed 4 ☐ Divorced	12. Was Decedant Armed Forcas  1  Yas 2  If Yas, Giva Yaar or Datas:	?	11	Vas Deced Yes, spec	ify Cuba	lispanic Orig an, Maxican, Specify:	jin? (Specify , Puarto Rica	Yas or No- an, etc.)	Blac	e - Amarica k, Whita, a whit	tc.	
15. Decedent's (Specify only highest of Elemantary/Secondary (0-12)		16	Sa. Deced	ent's Usua	I Occup	ation during most	of working		16b. Kind of Bu	sinass/Indu	ustry	
(Specify only highest s	College (1-4or	5+)	lifa. E	OO NOT us	a ratire	during most d)	or working					
0	2		omen	naker					Home	2		
17. Father's Nama (First, Middla, La	ist)					18. Motha	r's Name (Fi	rst, Middla,	Maidan Sumam	a)		
George Pee	k Marr	OW				Lau	ra	Reyn	olds			
19a. Informant's Name/Relationship	(Type, Print)	15	9b. Mallin	g Address	(Streat	and Numba	r or Rural R	outa Numbe	r, City or Town,	Stata, Zip (	Coda)	
Laurance Casl	er (son)	3	0564	Ski	ipto	on-Co	rdova	a Rd.	Cordo	ova,	MD 2162	25
20a. Method of Disposition		20b. Place	of Dispos		na of				20c. Location -			
1 Burial 2 Cramation 3 4 Donation 5 Other (Spe						tory	8/22	/98	Dover,	De1		
21. Signature of Funaral Sarvice Lie	-	ОПР				ss of Fecility						
21. Signature of the control of the	< n//	E10						me of	Steph	nen S	chaech	
23a. Part Lintar tha disaasa, or co	May -	1510	Вс	x 23	35,	Gale	na, l	MD 21	635			
Immediate Causa (Final disease or condition rasulting in death)	a. Enc	Due to (or as	ge a conseq		mo	navy	Int	ersti	ial fi	6/05	is lye	av
Sequentially list conditions, it any, leading to immediate	b	Due to (or as	a consaq	uanca of):								
	C	D. C. L. C.		ture A								
Cause (Disaasa or Injury that initiated avants resulting in death) Lest		Due to (or es	e consequ	uence of):								
NS.	d									1		
- E				_						1		
Part II. Other significant conditions  Metastatic	Breast	Conc	in tha ur	ndarlying co	ause giv	ven in Part I.		23b. Did to	-/		the cause of deal	
9	1- ,							04- 111		24h 14/-	ra autopsy finding	
Completed Completed	ract 1	rfect	con					24a. Was a perfor	med?	ava	ilabla prior to oplation of cause aath?	5
F .								1 □ Y	es 2 No	1 🗆	Yas 2 No	
ō						26. Placa	of Death (C	heck only or	na)	1		
25. Was casa referred to medical												
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DHMH 16 Rev 6/95

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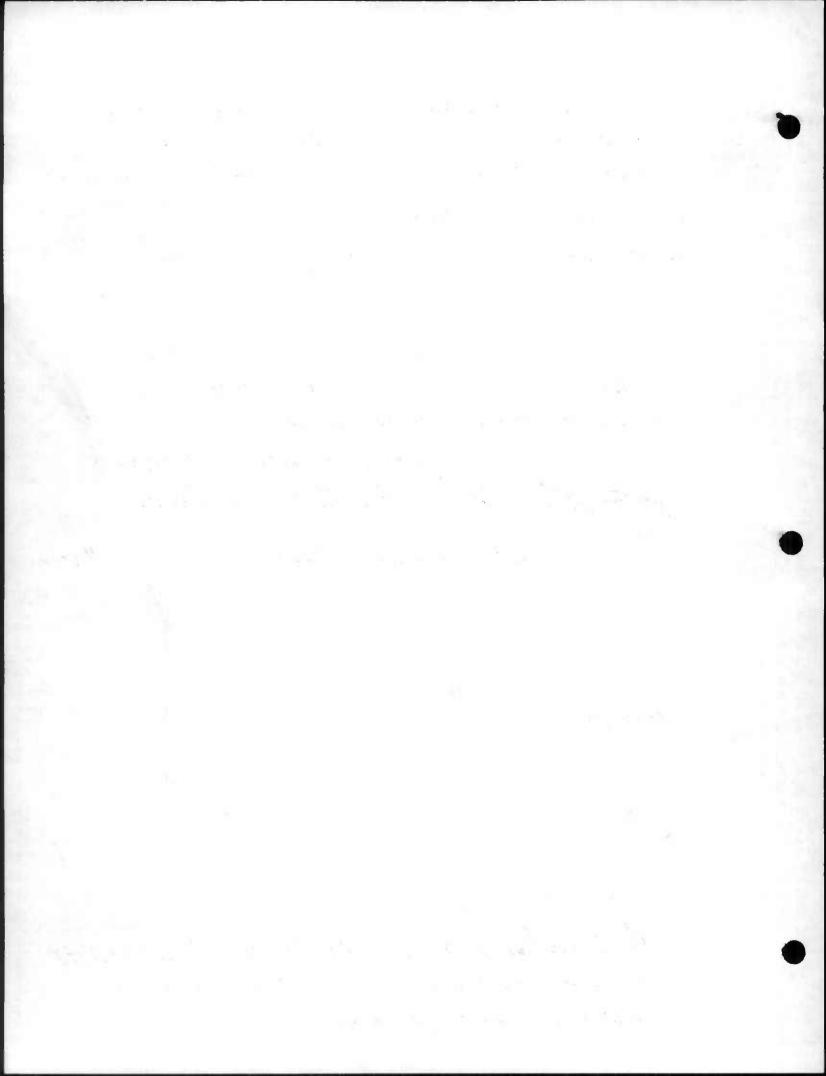
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DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene

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#### Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death AUGUST Day Physician CLEARWATER 06:400 HARVEY ELTING 13 1998 /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) Aug. 30, 1929 5. Sociel Security Number 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Hours Months 10 M 2□ F New York 083-22-5061 68 Yrs. Director Usual Residence of Decedent death with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worde | r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at XX Yes 2 No Director Prince George's Maryland College Park 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5902 Bryn Mawr Road 20740 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? YCXYes 2 □ No If Yes, Give Yeer or Dates: 1951–1954 14. Race - American Indien, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours affar of Department of Health and Mentel Hygiena. Important: if them 27 is marked other than "natural", or hen only Injury or other traumatic event, the market handle. 1 Never Married XX Married Specify: White 21215-0020 1 Yes 2XXNo Specify: þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Professor Univ. of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Elting Clearwater Velma Palmatier 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) Helen L. Clearwater (wife) same as #10 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) Date 20c. Location - City or Town, State 4 □ Qonation 5 □ Other (Specify) Metropolitan Crematory 8/14/1998 Alexandria, Virginia 21. Signature of Funeral S 22. Name end Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or colliplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediata Cause (Final disease or condition resulting in deeth) PNEUMONIA DAYS Examiner Dua to (or es a consequence of) Examiner BOWEL OBSTRUCTION YEAR Sequantially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daath) Last Due to (or es e consequence of): pug Box 68760, BLADDER CARCINOMA EARS Physician/Medical Due to (or es e consequence of): USB BS CARCINOMATOUS MENINGITIS Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physicien: 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only ona) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Dey Year) funeral 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Matural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide Hospitat 24 hours a Funerel D 10 Certifying Physician: To tha best of my knowledga, death occurred at the tima, data and place, and dua to tha causa(s) end menner as stated. 29a. Certifiar Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. To the I 29b. Signa ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODO July AUGUST 13, 1998 30. Name and address of person who completed causa of daeth (Item 23a) (Type, Print) BALTIMORE. MARYLAND IVAN AKSENTI JEVICH GOO N. WOLFE STREET. 31. Date filad (Month, Day, Year) 3. Registrar's Signeture State AUG 1 8 1998

**DHMH 16 Rev 6/95** 

Registrar

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Yaar **Physician** Herbert V. Cameron 17 1998 4c. County of Death 4b. City, Town, or Location of Death - /Medical 4a Facility Nama (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 €M 2 □ F Days 577-86-8318 86 Director November 4, 1911 Jamaica Usual Residence of Decedent with the Maryland 10a State 10d. Inside City Limits 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f sho the Medical Examinar must be notified at Hyattsville Mary land Prince George's Yas 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 7502 West Park Drive 20783 U.S.A. Funeral death 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 1 Yas 2XXNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elemantary/Secondary (0-12) Collaga (1-4or 5+) Janitorial INdustry 9th grade Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surnama) . Pagas 1 and 2 should be filt mant of Haelth end Mental Hy sant: If Item 27 is marked oth jury or other trsumatic even Be Janie Chambers Simeon Cameron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 6514 Ederton Drive Lanham, Maryland 20706 Mr. Patrick Cameron (Son) 20b. Place of Disposition (Name of 20a. Method of Disposition Data 20c. Location - City or Town, State National Harmony Memorial Park 8/22/98 1 X Burial 2 ☐ Cramation 3 ☐ Removal from State Landover, Maryland Department of Important: If 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. in the clease, or complications that ceused the death. Do not enter tha mode of dylng, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final CARDIOPULMONARY disaase or condition resulting in death) **Examiner** Examiner INFARCTION Tha law requires that the deeth cartificeta be axecuted physician and the burial-tran Sequentially list conditions, if any, laading to immediate ceusa. Entar Underlying Cause (Disease or Injury that Initiated avants resulting in death) Last MEUMONUA Physician/Medical 28 STEDMYEUTI usa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed by the a page 2 should be detached it 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown MELLITUS à 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy this certificate has 2 18 No 1 Yes 2 No 1 Yes 25. Was cese rafarrad to medical examiner? director, Be 26. Placa of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spacify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be detarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, atc. (Spacify)

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: efter daath. filled in by To the Hospital of within 24 hours of To the Funeral Discomplately filled

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29d. Data signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

4 Homicide

AUG 1 9 1998

AUGUST 17 1998

PARKUMY GREGREGE MARYLAMADOR

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

7325A HADROVER VICTOR Orey Chaka

32 Registrar's Signature

State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth Month

**Physician** /Medical Examiner

**Funeral** 

Director items 23e or 28a-f show iner must be notified at the the Medical Examiner ò "natural" nd Mental Hygiene. marked other than

permit. Pages 1 and 2 should be 1 Depertment of Health and Mental I Important: If item 27 is marked of eny injury or other traumatic eve **Physician** /Medical

**Examiner** 

Baltimore, Maryland 21215-0020

certificate be executed end -tre physician e 68760 Box P.O. s been signed by the should be detech Records, page 2 of Vital this After Division

or Attending I Director: A death. To the Hospital or Att filled pletely 1

1. Decedent's Neme (First, Middla, Last) 3. Time of Deeth MORDIS MURL COOK AUGUST 18,1998 1:10pm 4e. Fecility Neme (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MARINER HEALTHCARE OF LAUREL LAUREL PRINCE GEORGES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Hours 100M 20 F Yrs. 263-05-5260 84 Nov. 8,1913 FLORIDA Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥ Yes 2 No Director PRINCE GEORGES SEAT PLEASANT 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. Funeral 119 69th STREET 20743

13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? - American Indian, Bleck. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 1 ☐ Yes 2 ☐ No Specify: by Specify 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highast grada complated) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) FOREMAN PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surnama) JAMES LEWIS COOK SUSIE 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) PEARL E. COOK/WIFE 119 69th St. Seat Pleasant, Md. 20743 20b. Plece of Disposition (Name of cemetary, cramatory or othar placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Spacify) 8/24/98 LANDOVER, MD. HARMONY MEMORIAL PK 21. Signeture of Funeral Service Licensee JOHNSON & JENKINS INC. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. 716 KENNEDY ST., N.W. WASH. D.C. 20011 Approximate Intervel Betw e Left bower labe prenuma

Due to (or as e consequence of):

altzheimer's disease-final state Immediate Ceuse (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Physician/Medical Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably WUnknown by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the beginning by knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the base of the minetion and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manning plate. 29e. Certifier edicai 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) -01966 30. Name and address of person with se of death (Item 23e) (Type, Print)

G. A. DELATORRE, MD 14201 haurel Park Drive Suit 110 Laurel Md

20707

State Registrar 31. Dete filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

			otato or maryiat	Certificate o			j. No.	
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	/Medical	Chester		COOKE		AUGUST	Day 199	98 18:05 PM
	Examiner	4a Facility Nama (If not institution, giva THE JOHNS HOPKINS			4b. City, Town, or Lo BALTIMORE	cation of Death	4c. County of	Death
Г	Funeral Director	377-02-0930	7. Age (In yrs	O Yrs. If Under 1 Ya Months Day	s Hours Min.	8. Data of Birth (Month, Day, )		Birthplace (State or Foreign Country) ashington DC
	ehow dat	Usual Rasidance of Dacedant 10a. Stata 10b. County Maryland Prince G		ity, Town or Location	argo			10d. tnsida City Limits 1 □ Yes 2 □ No
	deem with the Marylend THE 23e of 28e-1 ehow The 13e of 28e-1 ehow The 13e of 28e-1 ehow	10e. Street and Number 9806 New Orchard	Drive	10f. Zip Code		109	g. Citizan of Who	at Country?
5-0020	elt, or its	11. Merital Status  1 Navar Marriad 2 Married  3 Widowed 4 Divorced	12. Was Dacedant Evar in the Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas:	J,S. 13. Was Decedant of If Yas, specify C	of Hispanic Origin? (Speuban, Maxicen, Puarto to Specify:	ocify Yes or No- Rican, atc.)	Black,	Amarican Indian, Whita, atc. Black
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	ever Be	17. Father's Nama (First, Middla, Last) Chester A. Cooke	2	Office in	18. Mothar's Nama	(First, Middla, Ma	aidan Sumeme)	IIIIeiic
Maryland	ath and Mer 27 Is marke r traumatic	19a. Informant's Name/Ralationship (7) Rena P. Cooke/Wi		19b. Malling Addrass (Str. 9806 New Or	eet end Number or Rura	al Routa Number,	City or Town, St	
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68760,	the attanding physician and the for use as the buriel-transit by Sician/Medical Examiner	Cause (Disease or injury that initiated evants resulting in death) Last	b. End St Duato	(or as a consaquanca of):	R Dise	ASE	n`s	8 (eignt) mont
P.O.	2 8 C	Part II. Other significent conditions co		sulting in the underlying ceuse		23b. Dtd tob	1	ibute to the causa of death?  Probably 4 Unknown
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>	this certific ral director,	examiner?	Hospital:	☐ ER/Outpatient 3☐ DOA	Other	ma 5 🗆 Rasidan		(Specify)
on of	After this funeral di	27. Mannar of Death  1 Natural 5 Panding 2 Accidant investigation	28a. Data of Injury (Month, Day Year)	28b. Time of thijury 28c. In		28d. Dascriba hov		
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	D)	30. Nama and addrass of person who of KATHIE POOVER  31. Data filed (Month, Day, Year)	,	KINS HOSPITI	AL TOWER	2 1, Per	1110	MARYLAND
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	State of Maryland	Department of	of Health	and	Mental	Hygiene
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Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** August 7, 1998 9:12 PM Mary Beatrice Cusic /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 24631 Blackistone Road Hollywood If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 6. Sax 7. Age (In yrs. lest birthday) If Under 1 Year Birthplaca (Stata or Foraign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 M 2 XF Months Days 218-12-9513 76 Director December 9, 1921 Maryland Usual Residence of Decedent with the Marylend permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show say injury or other traumatic svent, the Modical Examiner must be notified anone. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 36 U.S.A. 25029 Briscoe Road Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ XNo If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Nevar Married 2 X Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: ò 3 ☐ Widowad 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8th Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Beatrice Wallace Albert L. Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 44572 Joy Chapel Road, Hollywood, MD 20636 Joseph M. Cusic/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other placa) Date 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Other (Specify) 8/10/98 St. John's Cemetery Hollywood, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** relengtic Centrovaranda /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner discure physicien end the buriel-trensit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): certificate be execu Box 68760 Physician/Medical Dua to (or as a consaquance of): esn signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 1 Natural 2 Accidant Injury 5 Panding death. 1 Yes 2 No investigation after death Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) edicai within 2. 29b. Signature and title of certifies 29c. Licansa numbar 29d. Date signad (Month, Day, Year) 14285 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonardtown, Maryland 20650 William Boyd, II, MD 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 1 0 1998 Registrar

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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral Director		□ M 20XF		Yrs. Months				Yeer) 18, 1911	Country	e (Stete or Fore ) rnia
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or 28a-f s	10e. Street end Number				ip Code			0g. Citizen of V	Vhet Country	?
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or or or	1 ☐ Buriel 2 X Cremetion 3 ☐						0 / 5 / 0 0			
mant: lury	4 Donetion 5 Other (Specify	)	Metro	opolitan (	Cremat	ory	8/5/98	Alexand	ria, Vi	rginia
Department of Haai Important: if Item 2 any Injury or other once.	21. Signature of Funeral Service Licen 23e. Part1. Enter the disease, of compshock, or heart failure. List only	rn Lan	ine g	Matti P.O.	ngle Box	ess of Fecility y-Gardin 270, Leo ing, such es cerdia	nardtown	, Maryl	and 20	650 pproximate
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ath. r: Aftar this ia funaral di atlon: To	27. Menner of Death  1 Naturel 5 Pending investigation	28e. Date of Injui (Month, De)		Time of Injury	28c. Inju		28d. Describe h			
within 24 hours after death.  To the Funeral Director: After this complately filled in by the funeral of Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At home, f :. (Specify)	arm, street, fecto	ory, office		28f. Location (S City or Tox	itreet end Numb n, Stete)	per or Rurel F	Route Number,
e Funer piataly fill edical	29a. Certifier 1⊠ Certifying Phy (Check only 2 Medical Examone)	ysician: To the best of liner: On the basis of end menner ste	examination er							
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	30. Neme end eddress of person who	completed cause of de	eeth (Item 23e)	(Type, Print)						
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State	31. Dete filed (Month, Day, Yeer)	32. Registre	r's Signeture	0.111						
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